



General Assembly

Amendment

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LCO No. 5589

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Offered by:

SEN. HARP, 10th Dist.

SEN. HANDLEY, 4th Dist.

SEN. MURPHY, 16th Dist.

REP. MERRILL, 54th Dist.

REP. VILLANO, 91st Dist.

REP. SAYERS, 60th Dist.

To: Senate Bill No. 703

File No.

Cal. No. 512

"AN ACT REQUIRING A STUDY OF STATE SOCIAL SERVICES INSTITUTIONS AND DEPARTMENTS WITH RESPECT TO THE EXPENDITURES OF SUCH INSTITUTIONS AND DEPARTMENTS AND THE PROGRAMS ADMINISTERED OR SERVICES PROVIDED BY SUCH INSTITUTIONS AND DEPARTMENTS."

1 Strike everything after the enacting clause and substitute the
2 following in lieu thereof:

3 "Section 1. Subsection (a) of section 17b-340 of the 2006 supplement
4 to the general statutes is repealed and the following is substituted in
5 lieu thereof (*Effective July 1, 2006*):

6 (a) The rates to be paid by or for persons aided or cared for by the
7 state or any town in this state to licensed chronic and convalescent
8 nursing homes, to chronic disease hospitals associated with chronic
9 and convalescent nursing homes, to rest homes with nursing
10 supervision, to licensed residential care homes, as defined by section
11 19a-490, as amended, and to residential facilities for the mentally

12 retarded which are licensed pursuant to section 17a-227 and certified
13 to participate in the Title XIX Medicaid program as intermediate care
14 facilities for the mentally retarded, for room, board and services
15 specified in licensing regulations issued by the licensing agency shall
16 be determined annually, except as otherwise provided in this
17 subsection, after a public hearing, by the Commissioner of Social
18 Services, to be effective July first of each year except as otherwise
19 provided in this subsection. Such rates shall be determined on a basis
20 of a reasonable payment for such necessary services, which basis shall
21 take into account as a factor the costs of such services. Cost of such
22 services shall include reasonable costs mandated by collective
23 bargaining agreements with certified collective bargaining agents or
24 other agreements between the employer and employees, provided
25 "employees" shall not include persons employed as managers or chief
26 administrators or required to be licensed as nursing home
27 administrators, and compensation for services rendered by proprietors
28 at prevailing wage rates, as determined by application of principles of
29 accounting as prescribed by said commissioner. Cost of such services
30 shall not include amounts paid by the facilities to employees as salary,
31 or to attorneys or consultants as fees, where the responsibility of the
32 employees, attorneys, or consultants is to persuade or seek to persuade
33 the other employees of the facility to support or oppose unionization.
34 Nothing in this subsection shall prohibit inclusion of amounts paid for
35 legal counsel related to the negotiation of collective bargaining
36 agreements, the settlement of grievances or normal administration of
37 labor relations. The commissioner may, in his discretion, allow the
38 inclusion of extraordinary and unanticipated costs of providing
39 services which were incurred to avoid an immediate negative impact
40 on the health and safety of patients. The commissioner may, in his
41 discretion, based upon review of a facility's costs, direct care staff to
42 patient ratio and any other related information, revise a facility's rate
43 for any increases or decreases to total licensed capacity of more than
44 ten beds or changes to its number of licensed rest home with nursing
45 supervision beds and chronic and convalescent nursing home beds.
46 The commissioner may so revise a facility's rate established for the

47 fiscal year ending June 30, 1993, and thereafter for any bed increases,
48 decreases or changes in licensure effective after October 1, 1989.
49 Effective July 1, 1991, in facilities which have both a chronic and
50 convalescent nursing home and a rest home with nursing supervision,
51 the rate for the rest home with nursing supervision shall not exceed
52 such facility's rate for its chronic and convalescent nursing home. All
53 such facilities for which rates are determined under this subsection
54 shall report on a fiscal year basis ending on the thirtieth day of
55 September. Such report shall be submitted to the commissioner by the
56 thirty-first day of December. The commissioner may reduce the rate in
57 effect for a facility which fails to report on or before such date by an
58 amount not to exceed ten per cent of such rate. The commissioner shall
59 annually, on or before the fifteenth day of February, report the data
60 contained in the reports of such facilities to the joint standing
61 committee of the General Assembly having cognizance of matters
62 relating to appropriations. For the cost reporting year commencing
63 October 1, 1985, and for subsequent cost reporting years, facilities shall
64 report the cost of using the services of any nursing pool employee by
65 separating said cost into two categories, the portion of the cost equal to
66 the salary of the employee for whom the nursing pool employee is
67 substituting shall be considered a nursing cost and any cost in excess
68 of such salary shall be further divided so that seventy-five per cent of
69 the excess cost shall be considered an administrative or general cost
70 and twenty-five per cent of the excess cost shall be considered a
71 nursing cost, provided if the total nursing pool costs of a facility for
72 any cost year are equal to or exceed fifteen per cent of the total nursing
73 expenditures of the facility for such cost year, no portion of nursing
74 pool costs in excess of fifteen per cent shall be classified as
75 administrative or general costs. The commissioner, in determining
76 such rates, shall also take into account the classification of patients or
77 boarders according to special care requirements or classification of the
78 facility according to such factors as facilities and services and such
79 other factors as he deems reasonable, including anticipated
80 fluctuations in the cost of providing such services. The commissioner
81 may establish a separate rate for a facility or a portion of a facility for

82 traumatic brain injury patients who require extensive care but not
83 acute general hospital care. Such separate rate shall reflect the special
84 care requirements of such patients. If changes in federal or state laws,
85 regulations or standards adopted subsequent to June 30, 1985, result in
86 increased costs or expenditures in an amount exceeding one-half of
87 one per cent of allowable costs for the most recent cost reporting year,
88 the commissioner shall adjust rates and provide payment for any such
89 increased reasonable costs or expenditures within a reasonable period
90 of time retroactive to the date of enforcement. Nothing in this section
91 shall be construed to require the Department of Social Services to
92 adjust rates and provide payment for any increases in costs resulting
93 from an inspection of a facility by the Department of Public Health.
94 Such assistance as the commissioner requires from other state agencies
95 or departments in determining rates shall be made available to him at
96 his request. Payment of the rates established hereunder shall be
97 conditioned on the establishment by such facilities of admissions
98 procedures which conform with this section, section 19a-533 and all
99 other applicable provisions of the law and the provision of equality of
100 treatment to all persons in such facilities. The established rates shall be
101 the maximum amount chargeable by such facilities for care of such
102 beneficiaries, and the acceptance by or on behalf of any such facility of
103 any additional compensation for care of any such beneficiary from any
104 other person or source shall constitute the offense of aiding a
105 beneficiary to obtain aid to which he is not entitled and shall be
106 punishable in the same manner as is provided in subsection (b) of
107 section 17b-97. For the fiscal year ending June 30, 1992, rates for
108 licensed residential care homes and intermediate care facilities for the
109 mentally retarded may receive an increase not to exceed the most
110 recent annual increase in the Regional Data Resources Incorporated
111 McGraw-Hill Health Care Costs: Consumer Price Index (all urban)-All
112 Items. Rates for newly certified intermediate care facilities for the
113 mentally retarded shall not exceed one hundred fifty per cent of the
114 median rate of rates in effect on January 31, 1991, for intermediate care
115 facilities for the mentally retarded certified prior to February 1, 1991.
116 Notwithstanding any provision of this section, the Commissioner of

117 Social Services may, within available appropriations, provide an
118 interim rate increase for a licensed chronic and convalescent nursing
119 home or a rest home with nursing supervision for rate periods no
120 earlier than April 1, 2004, only if the commissioner determines that the
121 increase is necessary to avoid the filing of a petition for relief under
122 Title 11 of the United States Code; imposition of receivership pursuant
123 to sections 19a-541 to 19a-549, inclusive; or substantial deterioration of
124 the facility's financial condition that may be expected to adversely
125 affect resident care and the continued operation of the facility, and the
126 commissioner determines that the continued operation of the facility is
127 in the best interest of the state. The commissioner shall consider any
128 requests for interim rate increases on file with the department from
129 March 30, 2004, and those submitted subsequently for rate periods no
130 earlier than April 1, 2004. When reviewing a rate increase request the
131 commissioner shall, at a minimum, consider: (1) Existing chronic and
132 convalescent nursing home or rest home with nursing supervision
133 utilization in the area and projected bed need; (2) physical plant long-
134 term viability and the ability of the owner or purchaser to implement
135 any necessary property improvements; (3) licensure and certification
136 compliance history; [and] (4) reasonableness of actual and projected
137 expenses; [, but shall not consider the immediate profitability of the
138 operation of the facility] and (5) the ability of the facility to meet wage
139 and benefit costs. No rate shall be increased pursuant to this
140 subsection in excess of one hundred fifteen per cent of the median rate
141 for the facility's peer grouping, established pursuant to subdivision (2)
142 of subsection (f) of this section, unless recommended by the
143 commissioner and approved by the Secretary of the Office of Policy
144 and Management after consultation with the commissioner. Such
145 median rates shall be published by the Department of Social Services
146 not later than April first of each year. In the event that a facility
147 granted an interim rate increase pursuant to this section is sold or
148 otherwise conveyed for value to an unrelated entity less than five years
149 after the effective date of such rate increase, the rate increase shall be
150 deemed rescinded and the department shall recover an amount equal
151 to the difference between payments made for all affected rate periods

152 and payments that would have been made if the interim rate increase
153 was not granted. The commissioner may seek recovery from payments
154 made to any facility with common ownership. With the approval of
155 the Secretary of the Office of Policy and Management, the
156 commissioner may waive recovery and rescission of the interim rate
157 for good cause shown that is not inconsistent with this section,
158 including, but not limited to, transfers to family members that were
159 made for no value. The commissioner shall provide written quarterly
160 reports to the joint standing committees of the General Assembly
161 having cognizance of matters relating to human services and
162 appropriations and the budgets of state agencies and to the select
163 committee of the General Assembly having cognizance of matters
164 relating to aging, that identify each facility requesting an interim rate
165 increase, the amount of the requested rate increase for each facility, the
166 action taken by the commissioner and the secretary pursuant to this
167 subsection, and estimates of the additional cost to the state for each
168 approved interim rate increase. [Notwithstanding any provision of the
169 general statutes, on and after July 1, 2005, the commissioner shall not
170 provide an interim rate increase for a licensed chronic and
171 convalescent nursing home or a rest home with nursing supervision.]
172 Nothing in this subsection shall prohibit the commissioner from
173 increasing the rate of a licensed chronic and convalescent nursing
174 home or a rest home with nursing supervision for allowable costs
175 associated with facility capital improvements or increasing the rate in
176 case of a sale of a licensed chronic and convalescent nursing home or a
177 rest home with nursing supervision, pursuant to subdivision (16) of
178 subsection (f) of this section, if receivership has been imposed on such
179 home.

180 Sec. 2. Subdivision (4) of subsection (f) of section 17b-340 of the 2006
181 supplement to the general statutes is repealed and the following is
182 substituted in lieu thereof (*Effective July 1, 2006*):

183 (4) For the fiscal year ending June 30, 1992, (A) no facility shall
184 receive a rate that is less than the rate it received for the rate year
185 ending June 30, 1991; (B) no facility whose rate, if determined pursuant

186 to this subsection, would exceed one hundred twenty per cent of the
187 state-wide median rate, as determined pursuant to this subsection,
188 shall receive a rate which is five and one-half per cent more than the
189 rate it received for the rate year ending June 30, 1991; and (C) no
190 facility whose rate, if determined pursuant to this subsection, would be
191 less than one hundred twenty per cent of the state-wide median rate,
192 as determined pursuant to this subsection, shall receive a rate which is
193 six and one-half per cent more than the rate it received for the rate year
194 ending June 30, 1991. For the fiscal year ending June 30, 1993, no
195 facility shall receive a rate that is less than the rate it received for the
196 rate year ending June 30, 1992, or six per cent more than the rate it
197 received for the rate year ending June 30, 1992. For the fiscal year
198 ending June 30, 1994, no facility shall receive a rate that is less than the
199 rate it received for the rate year ending June 30, 1993, or six per cent
200 more than the rate it received for the rate year ending June 30, 1993.
201 For the fiscal year ending June 30, 1995, no facility shall receive a rate
202 that is more than five per cent less than the rate it received for the rate
203 year ending June 30, 1994, or six per cent more than the rate it received
204 for the rate year ending June 30, 1994. For the fiscal years ending June
205 30, 1996, and June 30, 1997, no facility shall receive a rate that is more
206 than three per cent more than the rate it received for the prior rate
207 year. For the fiscal year ending June 30, 1998, a facility shall receive a
208 rate increase that is not more than two per cent more than the rate that
209 the facility received in the prior year. For the fiscal year ending June
210 30, 1999, a facility shall receive a rate increase that is not more than
211 three per cent more than the rate that the facility received in the prior
212 year and that is not less than one per cent more than the rate that the
213 facility received in the prior year, exclusive of rate increases associated
214 with a wage, benefit and staffing enhancement rate adjustment added
215 for the period from April 1, 1999, to June 30, 1999, inclusive. For the
216 fiscal year ending June 30, 2000, each facility, except a facility with an
217 interim rate or replaced interim rate for the fiscal year ending June 30,
218 1999, and a facility having a certificate of need or other agreement
219 specifying rate adjustments for the fiscal year ending June 30, 2000,
220 shall receive a rate increase equal to one per cent applied to the rate the

221 facility received for the fiscal year ending June 30, 1999, exclusive of
222 the facility's wage, benefit and staffing enhancement rate adjustment.
223 For the fiscal year ending June 30, 2000, no facility with an interim rate,
224 replaced interim rate or scheduled rate adjustment specified in a
225 certificate of need or other agreement for the fiscal year ending June
226 30, 2000, shall receive a rate increase that is more than one per cent
227 more than the rate the facility received in the fiscal year ending June
228 30, 1999. For the fiscal year ending June 30, 2001, each facility, except a
229 facility with an interim rate or replaced interim rate for the fiscal year
230 ending June 30, 2000, and a facility having a certificate of need or other
231 agreement specifying rate adjustments for the fiscal year ending June
232 30, 2001, shall receive a rate increase equal to two per cent applied to
233 the rate the facility received for the fiscal year ending June 30, 2000,
234 subject to verification of wage enhancement adjustments pursuant to
235 subdivision (15) of this subsection. For the fiscal year ending June 30,
236 2001, no facility with an interim rate, replaced interim rate or
237 scheduled rate adjustment specified in a certificate of need or other
238 agreement for the fiscal year ending June 30, 2001, shall receive a rate
239 increase that is more than two per cent more than the rate the facility
240 received for the fiscal year ending June 30, 2000. For the fiscal year
241 ending June 30, 2002, each facility shall receive a rate that is two and
242 one-half per cent more than the rate the facility received in the prior
243 fiscal year. For the fiscal year ending June 30, 2003, each facility shall
244 receive a rate that is two per cent more than the rate the facility
245 received in the prior fiscal year, except that such increase shall be
246 effective January 1, 2003, and such facility rate in effect for the fiscal
247 year ending June 30, 2002, shall be paid for services provided until
248 December 31, 2002, except any facility that would have been issued a
249 lower rate effective July 1, 2002, than for the fiscal year ending June 30,
250 2002, due to interim rate status or agreement with the department shall
251 be issued such lower rate effective July 1, 2002, and have such rate
252 increased two per cent effective June 1, 2003. For the fiscal year ending
253 June 30, 2004, rates in effect for the period ending June 30, 2003, shall
254 remain in effect, except any facility that would have been issued a
255 lower rate effective July 1, 2003, than for the fiscal year ending June 30,

256 2003, due to interim rate status or agreement with the department shall
257 be issued such lower rate effective July 1, 2003. For the fiscal year
258 ending June 30, 2005, rates in effect for the period ending June 30, 2004,
259 shall remain in effect until December 31, 2004, except any facility that
260 would have been issued a lower rate effective July 1, 2004, than for the
261 fiscal year ending June 30, 2004, due to interim rate status or
262 agreement with the department shall be issued such lower rate
263 effective July 1, 2004. Effective January 1, 2005, each facility shall
264 receive a rate that is one per cent greater than the rate in effect
265 December 31, 2004. Effective upon receipt of all the necessary federal
266 approvals to secure federal financial participation matching funds
267 associated with the rate increase provided in this subdivision, but in
268 no event earlier than July 1, 2005, and provided the user fee imposed
269 under section 17b-320 of the 2006 supplement to the general statutes is
270 required to be collected, for the fiscal year ending June 30, 2006, the
271 department shall compute the rate for each facility based upon its 2003
272 cost report filing or, a subsequent cost year filing for facilities having
273 an interim rate for the period ending June 30, 2005, as provided under
274 section 17-311-55 of the regulations of Connecticut state agencies. For
275 each facility not having an interim rate for the period ending June 30,
276 2005, the rate for the period ending June 30, 2006, shall be determined
277 beginning with the higher of the computed rate based upon its 2003
278 cost report filing or the rate in effect for the period ending June 30,
279 2005. Such rate shall then be increased by [\$11.80] eleven dollars and
280 eighty cents per day except that in no event shall the rate for the period
281 ending June 30, 2006, be [\$32.00] thirty-two dollars more than the rate
282 in effect for the period ending June 30, 2005, and for any facility with a
283 rate below [\$195.00] one hundred ninety-five dollars per day for the
284 period ending June 30, 2005, such rate for the period ending June 30,
285 2006, shall not be greater than [\$217.43] two hundred seventeen dollars
286 and forty-three cents per day and for any facility with a rate equal to or
287 greater than [\$195.00] one hundred ninety-five dollars per day for the
288 period ending June 30, 2005, such rate for the period ending June 30,
289 2006, shall not exceed the rate in effect for the period ending June 30,
290 2005, increased by eleven and one-half per cent. For each facility with

291 an interim rate for the period ending June 30, 2005, the interim
292 replacement rate for the period ending June 30, 2006, shall not exceed
293 the rate in effect for the period ending June 30, 2005, increased by
294 [\$11.80] eleven dollars and eighty cents per day plus the per day cost
295 of the user fee payments made pursuant to section 17b-320 of the 2006
296 supplement to the general statutes divided by annual resident service
297 days, except for any facility with an interim rate below [\$195.00] one
298 hundred ninety-five dollars per day for the period ending June 30,
299 2005, the interim replacement rate for the period ending June 30, 2006,
300 shall not be greater than [\$217.43] two hundred seventeen dollars and
301 forty-three cents per day and for any facility with an interim rate equal
302 to or greater than [\$195.00] one hundred ninety-five dollars per day for
303 the period ending June 30, 2005, the interim replacement rate for the
304 period ending June 30, 2006, shall not exceed the rate in effect for the
305 period ending June 30, 2005, increased by eleven and one-half per cent.
306 Such July 1, 2005, rate adjustments shall remain in effect unless (i) the
307 federal financial participation matching funds associated with the rate
308 increase are no longer available; or (ii) the user fee created pursuant to
309 section 17b-320 of the 2006 supplement to the general statutes is not in
310 effect. For fiscal year ending June 30, 2007, [all facility rates] each
311 facility shall receive a rate that is three per cent greater than the rate in
312 effect for the period ending June 30, 2006, [shall remain in effect,]
313 except for any facility that would have been issued a lower rate
314 effective July 1, 2006, than for the rate period ending June 30, 2006, due
315 to interim rate status or agreement with the department, shall be
316 issued such lower rate effective July 1, 2006. The Commissioner of
317 Social Services shall add fair rent increases to any other rate increases
318 established pursuant to this subdivision for a facility which has
319 undergone a material change in circumstances related to fair rent.
320 Interim rates may take into account reasonable costs incurred by a
321 facility, including wages and benefits.

322 Sec. 3. Subdivision (16) of subsection (f) of section 17b-340 of the
323 2006 supplement to the general statutes is repealed and the following
324 is substituted in lieu thereof (*Effective July 1, 2006*):

325 (16) The interim rate established to become effective upon sale of
326 any licensed chronic and convalescent home or rest home with nursing
327 supervision for which a receivership has been imposed pursuant to
328 sections 19a-541 to 19a-549, inclusive, shall not exceed the rate in effect
329 for the facility at the time of the imposition of the receivership, subject
330 to any annual increases permitted by this section; provided if such rate
331 is less than the median rate for the facility's peer grouping, as defined
332 in subdivision (2) of this subsection, the Commissioner of Social
333 Services may, in the commissioner's discretion, establish an increased
334 rate for the facility not to exceed such median rate unless the Secretary
335 of the Office of Policy and Management, after review of area nursing
336 facility bed availability and other pertinent factors, authorizes the
337 Commissioner of Social Services to establish a rate higher than the
338 median rate. In the event the rate in effect for the facility at the time of
339 imposition of the receivership is greater than the median rate for the
340 facility's peer grouping, as defined in subdivision (2) of this subsection,
341 the Secretary of the Office of Policy and Management, after review of
342 area nursing facility bed availability and other pertinent factors, may
343 authorize the Commissioner of Social Services to establish an increased
344 interim rate.

345 Sec. 4. Subsection (g) of section 17b-340 of the 2006 supplement to
346 the general statutes is repealed and the following is substituted in lieu
347 thereof (*Effective July 1, 2006*):

348 (g) For the fiscal year ending June 30, 1993, any intermediate care
349 facility for the mentally retarded with an operating cost component of
350 its rate in excess of one hundred forty per cent of the median of
351 operating cost components of rates in effect January 1, 1992, shall not
352 receive an operating cost component increase. For the fiscal year
353 ending June 30, 1993, any intermediate care facility for the mentally
354 retarded with an operating cost component of its rate that is less than
355 one hundred forty per cent of the median of operating cost
356 components of rates in effect January 1, 1992, shall have an allowance
357 for real wage growth equal to thirty per cent of the increase
358 determined in accordance with subsection (q) of section 17-311-52 of

the regulations of Connecticut state agencies, provided such operating cost component shall not exceed one hundred forty per cent of the median of operating cost components in effect January 1, 1992. Any facility with real property other than land placed in service prior to October 1, 1991, shall, for the fiscal year ending June 30, 1995, receive a rate of return on real property equal to the average of the rates of return applied to real property other than land placed in service for the five years preceding October 1, 1993. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the rate of return on real property for property items shall be revised every five years. The commissioner shall, upon submission of a request, allow actual debt service, comprised of principal and interest, in excess of property costs allowed pursuant to section 17-311-52 of the regulations of Connecticut state agencies, provided such debt service terms and amounts are reasonable in relation to the useful life and the base value of the property. For the fiscal year ending June 30, 1995, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall not be applied to real property costs. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, no rate shall exceed three hundred seventy-five dollars per day unless the commissioner, in consultation with the Commissioner of Mental Retardation, determines after a review of program and management costs, that a rate in excess of this amount is necessary for care and treatment of facility residents. For the fiscal year ending June 30, 2002, rate period, the Commissioner of Social Services shall increase the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies to update allowable fiscal year 2000 costs to include a three and one-half per cent inflation factor. For the fiscal year ending June 30, 2003, rate period, the commissioner shall increase the inflation adjustment for rates made in

394 accordance with subsection (p) of section 17-311-52 of the regulations
395 of Connecticut state agencies to update allowable fiscal year 2001 costs
396 to include a one and one-half per cent inflation factor, except that such
397 increase shall be effective November 1, 2002, and such facility rate in
398 effect for the fiscal year ending June 30, 2002, shall be paid for services
399 provided until October 31, 2002, except any facility that would have
400 been issued a lower rate effective July 1, 2002, than for the fiscal year
401 ending June 30, 2002, due to interim rate status or agreement with the
402 department shall be issued such lower rate effective July 1, 2002, and
403 have such rate updated effective November 1, 2002, in accordance with
404 applicable statutes and regulations. For the fiscal year ending June 30,
405 2004, rates in effect for the period ending June 30, 2003, shall remain in
406 effect, except any facility that would have been issued a lower rate
407 effective July 1, 2003, than for the fiscal year ending June 30, 2003, due
408 to interim rate status or agreement with the department shall be issued
409 such lower rate effective July 1, 2003. For the fiscal year ending June
410 30, 2005, rates in effect for the period ending June 30, 2004, shall
411 remain in effect until September 30, 2004. Effective October 1, 2004,
412 each facility shall receive a rate that is five per cent greater than the
413 rate in effect September 30, 2004. Effective upon receipt of all the
414 necessary federal approvals to secure federal financial participation
415 matching funds associated with the rate increase provided in
416 subdivision (4) of subsection (f) of this section, but in no event earlier
417 than October 1, 2005, and provided the user fee imposed under section
418 17b-320 of the 2006 supplement to the general statutes is required to be
419 collected, each facility shall receive a rate that is four per cent more
420 than the rate the facility received in the prior fiscal year, except any
421 facility that would have been issued a lower rate effective October 1,
422 2005, than for the fiscal year ending June 30, 2005, due to interim rate
423 status or agreement with the department, shall be issued such lower
424 rate effective October 1, 2005. Such rate increase shall remain in effect
425 unless: (A) The federal financial participation matching funds
426 associated with the rate increase are no longer available; or (B) the user
427 fee created pursuant to section 17b-320 of the 2006 supplement to the
428 general statutes is not in effect. For the fiscal year ending June 30, 2007,

429 rates in effect for the period ending June 30, 2006, shall remain in effect
430 until September 30, 2006, except any facility that would have been
431 issued a lower rate effective July 1, 2006, than for the fiscal year ending
432 June 30, 2006, due to interim rate status or agreement with the
433 department, shall be issued such lower rate effective July 1, 2006.
434 Effective October 1, 2006, no facility shall receive a rate that is more
435 than three per cent greater than the rate in effect for the facility on
436 September 30, 2006, except for any facility that would have been issued
437 a lower rate effective October 1, 2006, due to interim rate status or
438 agreement with the department, shall be issued such lower rate
439 effective October 1, 2006.

440 Sec. 5. Subdivision (1) of subsection (h) of section 17b-340 of the
441 2006 supplement to the general statutes is repealed and the following
442 is substituted in lieu thereof (*Effective July 1, 2006*):

443 (h) (1) For the fiscal year ending June 30, 1993, any residential care
444 home with an operating cost component of its rate in excess of one
445 hundred thirty per cent of the median of operating cost components of
446 rates in effect January 1, 1992, shall not receive an operating cost
447 component increase. For the fiscal year ending June 30, 1993, any
448 residential care home with an operating cost component of its rate that
449 is less than one hundred thirty per cent of the median of operating cost
450 components of rates in effect January 1, 1992, shall have an allowance
451 for real wage growth equal to sixty-five per cent of the increase
452 determined in accordance with subsection (q) of section 17-311-52 of
453 the regulations of Connecticut state agencies, provided such operating
454 cost component shall not exceed one hundred thirty per cent of the
455 median of operating cost components in effect January 1, 1992.
456 Beginning with the fiscal year ending June 30, 1993, for the purpose of
457 determining allowable fair rent, a residential care home with allowable
458 fair rent less than the twenty-fifth percentile of the state-wide
459 allowable fair rent shall be reimbursed as having allowable fair rent
460 equal to the twenty-fifth percentile of the state-wide allowable fair
461 rent. Beginning with the fiscal year ending June 30, 1997, a residential
462 care home with allowable fair rent less than three dollars and ten cents

per day shall be reimbursed as having allowable fair rent equal to three dollars and ten cents per day. Property additions placed in service during the cost year ending September 30, 1996, or any succeeding cost year shall receive a fair rent allowance for such additions as an addition to three dollars and ten cents per day if the fair rent for the facility for property placed in service prior to September 30, 1995, is less than or equal to three dollars and ten cents per day. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the allowance for real wage growth, as determined in accordance with subsection (q) of section 17-311-52 of the regulations of Connecticut state agencies, shall not be applied. For the fiscal year ending June 30, 1996, and any succeeding fiscal year, the inflation adjustment made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall not be applied to real property costs. Beginning with the fiscal year ending June 30, 1997, minimum allowable patient days for rate computation purposes for a residential care home with twenty-five beds or less shall be eighty-five per cent of licensed capacity. Beginning with the fiscal year ending June 30, 2002, for the purposes of determining the allowable salary of an administrator of a residential care home with sixty beds or less the department shall revise the allowable base salary to thirty-seven thousand dollars to be annually inflated thereafter in accordance with section 17-311-52 of the regulations of Connecticut state agencies. The rates for the fiscal year ending June 30, 2002, shall be based upon the increased allowable salary of an administrator, regardless of whether such amount was expended in the 2000 cost report period upon which the rates are based. Beginning with the fiscal year ending June 30, 2000, the inflation adjustment for rates made in accordance with subsection (p) of section 17-311-52 of the regulations of Connecticut state agencies shall be increased by two per cent, and beginning with the fiscal year ending June 30, 2002, the inflation adjustment for rates made in accordance with subsection (c) of said section shall be increased by one per cent. Beginning with the fiscal year ending June 30, 1999, for the purpose of determining the allowable salary of a related party, the department shall revise the

498 maximum salary to twenty-seven thousand eight hundred fifty-six
499 dollars to be annually inflated thereafter in accordance with section
500 17-311-52 of the regulations of Connecticut state agencies and
501 beginning with the fiscal year ending June 30, 2001, such allowable
502 salary shall be computed on an hourly basis and the maximum
503 number of hours allowed for a related party other than the proprietor
504 shall be increased from forty hours to forty-eight hours per work week.
505 For the fiscal year ending June 30, 2005, each facility shall receive a rate
506 that is two and one-quarter per cent more than the rate the facility
507 received in the prior fiscal year, except any facility that would have
508 been issued a lower rate effective July 1, 2004, than for the fiscal year
509 ending June 30, 2004, due to interim rate status or agreement with the
510 department shall be issued such lower rate effective July 1, 2004.
511 Effective upon receipt of all the necessary federal approvals to secure
512 federal financial participation matching funds associated with the rate
513 increase provided in subdivision (4) of subsection (f) of this section,
514 but in no event earlier than October 1, 2005, and provided the user fee
515 imposed under section 17b-320 of the 2006 supplement to the general
516 statutes is required to be collected, each facility shall receive a rate that
517 is determined in accordance with applicable law and subject to
518 appropriations, except any facility that would have been issued a
519 lower rate effective October 1, 2005, than for the fiscal year ending June
520 30, 2005, due to interim rate status or agreement with the department,
521 shall be issued such lower rate effective October 1, 2005. Such rate
522 increase shall remain in effect unless: (A) The federal financial
523 participation matching funds associated with the rate increase are no
524 longer available; or (B) the user fee created pursuant to section 17b-320
525 of the 2006 supplement to the general statutes is not in effect. For the
526 fiscal year ending June 30, 2007, rates in effect for the period ending
527 June 30, 2006, shall remain in effect until September 30, 2006, except
528 any facility that would have been issued a lower rate effective July 1,
529 2006, than for the fiscal year ending June 30, 2006, due to interim rate
530 status or agreement with the department, shall be issued such lower
531 rate effective July 1, 2006. Effective October 1, 2006, no facility shall
532 receive a rate that is more than four per cent greater than the rate in

533 effect for the facility on September 30, 2006, except for any facility that
534 would have been issued a lower rate effective October 1, 2006, due to
535 interim rate status or agreement with the department, shall be issued
536 such lower rate effective October 1, 2006.

537 Sec. 6. Subsection (a) of section 17b-321 of the 2006 supplement to
538 the general statutes is repealed and the following is substituted in lieu
539 thereof (*Effective July 1, 2006*):

540 (a) On or before July 1, 2005, and on or before July first [of each
541 succeeding calendar year] biennially thereafter, the Commissioner of
542 Social Services shall determine the amount of the user fee and
543 promptly notify the commissioner and nursing homes of such amount.
544 The user fee shall be the (1) the sum of each nursing home's anticipated
545 nursing home net revenue, including but not limited to its estimated
546 net revenue from any increases in Medicaid payments, during the
547 twelve-month period ending on June thirtieth of the succeeding
548 calendar year, (2) which sum shall be multiplied by six per cent, and
549 (3) which product shall be divided by the sum of each nursing home's
550 anticipated resident days during the twelve-month period ending on
551 June thirtieth of the succeeding calendar year. The Commissioner of
552 Social Services, in anticipating nursing home net revenue and resident
553 days, shall use the most recently available nursing home net revenue
554 and resident day information. On or before July 1, 2007, the
555 Commissioner of Social Services shall report, in accordance with
556 section 11-4a, to the joint standing committees of the General
557 Assembly having cognizance of matters relating to appropriations and
558 the budgets of state agencies and human services on the detrimental
559 effects, if any, that a biennial determination of the user fee may have
560 on private payors.

561 Sec. 7. Subsection (b) of section 17b-321 of the 2006 supplement to
562 the general statutes is repealed and the following is substituted in lieu
563 thereof (*Effective July 1, 2006*):

564 (b) Upon approval of the waiver of federal requirements for

565 uniform and broad-based user fees in accordance with 42 CFR 433.68
566 pursuant to section 17b-323, the Commissioner of Social Services shall
567 redetermine the amount of the user fee and promptly notify the
568 commissioner and nursing homes of such amount. The user fee shall
569 be the (1) the sum of each nursing home's anticipated nursing home
570 net revenue, including but not limited to its estimated net revenue
571 from any increases in Medicaid payments, during the twelve-month
572 period ending on June thirtieth of the succeeding calendar year but not
573 including any such anticipated net revenue of any nursing home
574 exempted from such user fee due to waiver of federal requirements
575 pursuant to section 17b-323, (2) which sum shall be multiplied by six
576 per cent, and (3) which product shall be divided by the sum of each
577 nursing home's anticipated resident days, but not including the
578 anticipated resident days of any nursing home exempted from such
579 user fee due to waiver of federal requirements pursuant to section 17b-
580 323. Notwithstanding the provisions of this subsection, the amount of
581 the user fee for each nursing home licensed for more than two
582 hundred thirty beds or owned by a municipality shall be equal to the
583 amount necessary to comply with federal provider tax uniformity
584 waiver requirements as determined by the Commissioner of Social
585 Services. The Commissioner of Social Services may increase
586 retroactively the user fee for nursing homes not licensed for more than
587 two hundred thirty beds and not owned by a municipality to the
588 effective date of waiver of said federal requirements to offset user fee
589 reductions necessary to meet the federal waiver requirements.
590 [Thereafter, on] On or before July [first of each succeeding calendar
591 year] 1, 2005, and biennially thereafter, the Commissioner of Social
592 Services shall determine the amount of the user fee in accordance with
593 this subsection. The Commissioner of Social Services, in anticipating
594 nursing home net revenue and resident days, shall use the most
595 recently available nursing home net revenue and resident day
596 information. On or before July 1, 2007, the Commissioner of Social
597 Services shall report, in accordance with section 11-4a, to the joint
598 standing committees of the General Assembly having cognizance of
599 matters relating to appropriations and the budgets of state agencies

600 and human services on the detrimental effects, if any, that a biennial
601 determination of the user fee may have on private payors.

602 Sec. 8. Section 17b-605a of the general statutes is repealed and the
603 following is substituted in lieu thereof (*Effective July 1, 2006*):

604 (a) The Commissioner of Social Services shall seek a waiver from
605 federal law to establish a personal care assistance program for persons
606 [ages eighteen through sixty-four] eighteen years of age or older with
607 disabilities funded under the Medicaid program. Such a program shall
608 be limited to a specified number of slots available for eligible program
609 recipients and shall be operated by the Department of Social Services
610 within available appropriations. Such a waiver shall be submitted to
611 the joint standing committees of the General Assembly having
612 cognizance of matters relating to appropriations and the budgets of
613 state agencies and human services in accordance with section 17b-8 no
614 later than January 1, 1996.

615 (b) The Commissioner of Social Services shall amend the waiver
616 specified in subsection (a) of this section to enable persons eligible for
617 or receiving medical assistance under section 17b-597 to receive
618 personal care assistance. Such amendment shall not be subject to the
619 provisions of section 17b-8 provided such amendment shall consist
620 only of modifications necessary to extend personal care assistance to
621 such persons.

622 Sec. 9. Subsection (a) of section 17b-342a of the 2006 supplement to
623 the general statutes is repealed and the following is substituted in lieu
624 thereof (*Effective July 1, 2006*):

625 (a) The Commissioner of Social Services shall, within available
626 appropriations, establish and operate a state-funded pilot program to
627 allow no more than [one] two hundred fifty persons who are sixty-five
628 years of age or older and meet the eligibility requirements of the
629 Connecticut home-care program for the elderly established under
630 section 17b-342, as amended, to receive personal care assistance
631 provided such services are cost effective as determined by the

632 Commissioner of Social Services. Persons who receive personal care
633 assistance services pursuant to the pilot program established by
634 section 47 of public act 00-2 of the June special session* shall be
635 included as participants of the pilot program established pursuant to
636 this section. Personal care assistance under the program may be
637 provided by nonspousal family members of the recipient of services
638 under the program.

639 Sec. 10. (NEW) (*Effective July 1, 2006*) On and after July 1, 2006, and
640 for each succeeding fiscal year thereafter, in determining costs eligible
641 for reimbursement pursuant to subdivisions (2) and (3) of subsection
642 (e) of section 10-76d of the 2006 supplement to the general statutes,
643 subdivision (2) of subsection (a) of section 10-76g of the 2006
644 supplement to the general statutes and subsection (b) of said section
645 10-76g, Medicaid reimbursement received by any local or regional
646 board of education from the Department of Social Services for students
647 of such boards of education shall not be deducted from grants paid in
648 accordance with said sections of the general statutes.

649 Sec. 11. Subsection (b) of section 17b-490 of the 2006 supplement to
650 the general statutes is repealed and the following is substituted in lieu
651 thereof (*Effective July 1, 2006*):

652 (b) "Prescription drugs" means (1) legend drugs, as defined in
653 section 20-571, (2) any other drugs which by state law or regulation
654 require the prescription of a licensed practitioner for dispensing,
655 except: (A) Products prescribed for cosmetic purposes as specified in
656 regulations adopted pursuant to section 17b-494; (B) on and after
657 September 15, 1991, diet pills, smoking cessation gum, contraceptives,
658 multivitamin combinations, cough preparations and antihistamines;
659 [and] (C) drugs for the treatment of erectile dysfunction, unless such
660 drug is prescribed to treat a condition other than sexual or erectile
661 dysfunction, for which the drug has been approved by the Food and
662 Drug Administration; and (D) drugs for the treatment of erectile
663 dysfunction for persons who have been convicted of a sexual offense
664 who are required to register with the Commissioner of Public Safety

665 pursuant to chapter 969, and (3) insulin and insulin syringes.

666 Sec. 12. Section 17b-363b of the general statutes is repealed and the
667 following is substituted in lieu thereof (*Effective July 1, 2006*):

668 (a) The Commissioner of Social Services may, within available
669 appropriations, provide reimbursement to pharmacies or pharmacists
670 for services provided to residents in long-term care facilities, including
671 (1) residential care homes, nursing homes or rest homes, as defined in
672 section 19a-490, as amended, (2) residential facilities for mentally
673 retarded persons, as defined in section 17a-231, or (3) facilities served
674 by assisted living services agencies, as defined in section 19a-490, as
675 amended, in addition to those reimbursements provided in chapter
676 319v, provided such services improve the quality of care to residents of
677 such facilities and produce cost savings to the state, as determined by
678 the commissioner. Such services may include, but not be limited to,
679 emergency and delivery services provided such services are offered on
680 all medications, including intravenous therapy, twenty-four hours per
681 day and seven days per week.

682 (b) The Commissioner of Social Services may reimburse for
683 prescription drug costs in unit dose packaging, including blister packs
684 and other special packaging, for clients residing in nursing facilities,
685 chronic disease hospitals and intermediate care facilities for the
686 mentally retarded.

687 Sec. 13. Section 17b-265e of the 2006 supplement to the general
688 statutes is repealed and the following is substituted in lieu thereof
689 (*Effective July 1, 2006*):

690 (a) There is established a fund to be known as the "Medicare Part D
691 Supplemental Needs Fund" which shall be an account within the
692 General Fund under the Department of Social Services. The
693 Commissioner of Social Services shall, within available appropriations,
694 designate moneys to said fund. Moneys available in said fund shall be
695 utilized by the Department of Social Services to provide financial
696 assistance to Medicare Part D beneficiaries who are enrolled in the

697 ConnPACE program or who are full benefit dually eligible Medicare
698 Part D beneficiaries, as defined in section 17b-265d, and who lack the
699 financial means to obtain medically necessary nonformulary
700 prescription drugs. A beneficiary requesting such financial assistance
701 from the department shall be required to make a satisfactory showing
702 of the medical necessity of obtaining such nonformulary prescription
703 drug to the department. The department may require as a condition of
704 receiving such financial assistance that a beneficiary establish, to the
705 satisfaction of the department, that the beneficiary has made good faith
706 efforts to: (1) Enroll in a Medicare Part D plan recommended by the
707 commissioner or the commissioner's agent; and (2) utilize the
708 exception process established by the prescription drug plan in which
709 the beneficiary is enrolled. The department shall expeditiously review
710 all requests for financial assistance pursuant to this section and shall
711 notify the beneficiary as to whether the request for financial assistance
712 has been granted not later than two hours after receiving the request
713 from the beneficiary. The commissioner shall implement policies and
714 procedures to administer the provisions of this section and to ensure
715 that all requests for, and determinations made concerning financial
716 assistance available pursuant to this section are expeditiously
717 processed.

718 (b) The Department of Social Services shall, in accordance with the
719 provisions of this section, pay claims for prescription drugs for
720 Medicare Part D beneficiaries, who are also either Medicaid or
721 ConnPACE recipients and who are denied coverage by the Medicare
722 Part D Plan in which such beneficiary is enrolled because a prescribed
723 drug is not on the formulary utilized by such Medicare Part D Plan.
724 Payment shall initially be made by the department for a thirty-day
725 supply, subject to any applicable copayment. The beneficiary shall
726 appoint the commissioner as such beneficiary's representative for the
727 purpose of appealing any denial of Medicare Part D benefits and for
728 any other purpose allowed under said act and deemed necessary by
729 the commissioner.

730 (c) Notwithstanding any provision of the general statutes, not later

731 than July 1, 2006, the Commissioner of Social Services shall contract
732 with an entity specializing in Medicare appeals and reconsideration for
733 the purpose of having such entity exhaust remedies for pursuing
734 payment under Medicare Part D by Part D Plans for prescriptions
735 denied as nonformulary drugs, including remedies available through
736 reconsideration by an Independent Review Entity, review by an
737 Administrative Law Judge, the Medicare Appeals Council or Federal
738 District Court. Reimbursement secured by such entity from the Part D
739 Plan shall be returned to the Department of Social Services.

740 (d) The entity contracting with the Department of Social Services
741 pursuant to subsection (c) of this section shall submit appeals beyond
742 the Independent Review Entity only upon authorization from the
743 department. Upon determination by the department that it is not cost-
744 effective to pursue further appeals, the department shall pay for the
745 denied nonformulary drug for the remainder of the calendar year,
746 provided the beneficiary remains enrolled in the Part D Plan that
747 denied coverage. Pending the outcome of the appeals process, the
748 department shall continue to pay claims for the nonformulary drug
749 denied by the Part D Plan until the earlier of approval of such drug by
750 the Part D Plan or for the remainder of the calendar year.

751 Sec. 14. Section 17b-256 of the general statutes is repealed and the
752 following is substituted in lieu thereof (*Effective from passage*):

753 (a) The Commissioner of Social Services may administer, within
754 available appropriations, a program providing payment for the cost of
755 drugs prescribed by a physician for the [prevention or] treatment of
756 acquired immunodeficiency syndrome [(AIDS)] or human
757 immunodeficiency virus. [(HIV infection).] The commissioner, in
758 consultation with the Commissioner of Public Health, shall determine
759 specific drugs to be covered and may implement a pharmacy lock-in
760 procedure for the program. The [commissioner] Commissioner of
761 Social Services shall adopt regulations, in accordance with the
762 provisions of chapter 54, to carry out the purposes of this section. The
763 commissioner may implement the program while in the process of

764 adopting regulations, provided notice of intent to adopt the
765 regulations is published in the Connecticut Law Journal within twenty
766 days of implementation. The regulations may include eligibility for all
767 persons with [AIDS or HIV infection] acquired immunodeficiency
768 syndrome or human immunodeficiency virus whose income is below
769 four hundred per cent of the federal poverty level. [The] Subject to
770 federal approval, the commissioner [shall] may, within available
771 federal resources, [purchase and] maintain existing insurance policies
772 for eligible clients, including, but not limited to, coverage of costs
773 associated with such policies, that provide a full range of [HIV] human
774 immunodeficiency virus treatments and access to comprehensive
775 primary care services as determined by the commissioner and as
776 provided by federal law, and may provide payment, determined by
777 the commissioner, for (1) drugs and nutritional supplements
778 prescribed by a physician that prevent or treat opportunistic diseases
779 and conditions associated with [AIDS or HIV infection] acquired
780 immunodeficiency syndrome or human immunodeficiency virus; (2)
781 ancillary supplies related to the administration of such drugs; and (3)
782 laboratory tests ordered by a physician. On and after the effective date
783 of this section, persons who previously received insurance assistance
784 under the program established pursuant to section 17b-255 of the
785 general statutes, revision of 1958, revised to 2005, shall continue to
786 receive such assistance until the expiration of the insurance coverage,
787 provided such person continues to meet program eligibility
788 requirements established in accordance with this subsection. On or
789 before March 1, 2007, and annually thereafter, the Commissioner of
790 Social Services shall report, in accordance with section 11-4a, to the
791 joint standing committees of the General Assembly having cognizance
792 of matters relating to human services, public health and appropriations
793 and the budgets of state agencies on the projected availability of funds
794 for the program established pursuant to this section.

795 (b) Applicants for and recipients of benefits under the program
796 established pursuant to subsection (a) of this section shall, if eligible,
797 enroll in Medicare Part D. The Commissioner of Social Services may be

the authorized representative of such an applicant or recipient for purposes of enrolling in a Medicare Part D plan or submitting an application to the Social Security Administration to obtain the low income subsidy benefit provided under Public Law 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The applicant or recipient shall have the opportunity to select a Medicare Part D plan and shall be notified of such opportunity by the commissioner. The applicant or recipient, prior to selecting a Medicare Part D plan, shall have the opportunity to consult with the commissioner, or the commissioner's designated agent, concerning the selection of a Medicare Part D plan that best meets the prescription drug needs of such applicant or recipient. In the event that such applicant or recipient does not select a Medicare Part D plan within a reasonable period of time, as determined by the commissioner, the commissioner shall enroll the applicant or recipient in a Medicare Part D plan designated by the commissioner in accordance with said act. The applicant or recipient shall appoint the commissioner as such applicant's or recipient's representative for the purpose of appealing any denial of Medicare Part D benefits and for any other purpose allowed under said act and deemed necessary by the commissioner. The commissioner may pay the premium and coinsurance costs of Medicare Part D coverage for eligible applicants or recipients.

Sec. 15. Section 17b-242a of the 2006 supplement to the general statutes is repealed and the following is substituted in lieu thereof (Effective July 1, 2006):

The Commissioner of Social Services shall establish prior authorization procedures under the Medicaid program for home health services, such that prior authorization shall be required for skilled nursing visits that exceed two per week [. Unless there are revisions to the prior authorization received during the month, providers shall not] and for home health aide visits that exceed fourteen hours per week, except that no provider shall be required to submit a prior authorization [requests] request for a home health service for the same client more than once a month. The Commissioner

832 of Social Services may contract with an entity for administration of any
833 such aspect of prior authorization or may expand the scope of an
834 existing contract with an entity that performs utilization review
835 services on behalf of the department. The commissioner, pursuant to
836 section 17b-10, may implement policies and procedures necessary to
837 administer the provisions of this section while in the process of
838 adopting such policies and procedures as regulation, provided the
839 commissioner prints notice of intent to adopt regulations in the
840 Connecticut Law Journal not later than twenty days after the date of
841 implementation. Policies and procedures implemented pursuant to
842 this section shall be valid until the time final regulations are adopted.

843 Sec. 16. Subsection (j) of section 17b-292 of the 2006 supplement to
844 the general statutes is repealed and the following is substituted in lieu
845 thereof (*Effective July 1, 2006*):

846 (j) Not more than twelve months after the determination of
847 eligibility for benefits under the HUSKY Plan, Part A and Part B and
848 annually thereafter, the commissioner or the servicer, as the case may
849 be, shall determine if the child continues to be eligible for the plan. The
850 commissioner or the servicer shall mail an application form to each
851 participant in the plan for the purposes of obtaining information to
852 make a determination on eligibility. To the extent permitted by federal
853 law, in determining eligibility for benefits under the HUSKY Plan, Part
854 A or Part B with respect to family income, the commissioner or the
855 servicer shall rely upon information provided in such form by the
856 participant unless the commissioner or the servicer has reason to
857 believe that such information is inaccurate or incomplete. The
858 Department of Social Services shall annually review a random sample
859 of cases to confirm that, based on the statistical sample, relying on such
860 information is not resulting in ineligible clients receiving benefits
861 under HUSKY Plan Part A or Part B. The determination of eligibility
862 shall be coordinated with health plan open enrollment periods.

863 Sec. 17. Section 17b-84 of the general statutes is repealed and the
864 following is substituted in lieu thereof (*Effective July 1, 2006*):

865 Upon the death of any beneficiary [,] under the state supplement or
866 the temporary family assistance program, the [commissioner]
867 Commissioner of Social Services shall order the payment of a sum not
868 to exceed [one thousand dollars for the fiscal year ending June 30,
869 1987, one thousand one hundred dollars for the fiscal year ending June
870 30, 1988, and one thousand two hundred dollars for the fiscal year
871 ending June 30, 1989, and subsequent fiscal years,] one thousand eight
872 hundred dollars as an allowance toward the funeral and burial
873 expenses of such deceased. The payment for funeral and burial
874 expenses shall be reduced by the amount in any revocable or
875 irrevocable funeral fund, prepaid funeral contract or the face value of
876 any life insurance policy owned by the recipient. Contributions may be
877 made by any person for the cost of the funeral and burial expenses of
878 the deceased over and above the sum established under this section
879 without thereby diminishing the state's obligation.

880 Sec. 18. Section 17b-131 of the general statutes is repealed and the
881 following is substituted in lieu thereof (*Effective July 1, 2006*):

882 When a person in any town, or sent from such town to any licensed
883 institution or state humane institution, dies or is found dead therein
884 and does not leave sufficient estate or has no legally liable relative able
885 to pay the cost of a proper funeral and burial, or upon the death of any
886 beneficiary under the state-administered general assistance program,
887 the Commissioner of Social Services shall give to such person a proper
888 funeral and burial, and shall pay a sum not exceeding [twelve
889 hundred] one thousand eight hundred dollars as an allowance toward
890 the funeral expenses of such deceased, said sum to be paid, upon
891 submission of a proper bill, to the funeral director, cemetery or
892 crematory, as the case may be. Such payment for funeral and burial
893 expenses shall be reduced by (1) the amount in any revocable or
894 irrevocable funeral fund, (2) any prepaid funeral contract, (3) the face
895 value of any life insurance policy owned by the decedent, and (4)
896 contributions in excess of two thousand eight hundred dollars toward
897 such funeral and burial expenses from all other sources including
898 friends, relatives and all other persons, organizations, veterans and

899 other benefit programs and other agencies.

900 Sec. 19. Section 17b-264 of the general statutes is repealed and the
901 following is substituted in lieu thereof (*Effective July 1, 2006*):

902 All of the provisions of sections 17b-22, 17b-75 to 17b-77, inclusive,
903 17b-79 to 17b-83, inclusive, 17b-85 to 17b-103, inclusive, and 17b-600 to
904 17b-604, inclusive, are extended to the medical assistance program
905 except such provisions as are inconsistent with federal law and
906 regulations governing Title XIX of the Social Security Amendments of
907 1965 and sections 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285,
908 inclusive, as amended, and 17b-357 to 17b-361, inclusive.

909 Sec. 20. Section 19a-55a of the general statutes is repealed and the
910 following is substituted in lieu thereof (*Effective July 1, 2006*):

911 (a) There is established a newborn screening account that shall be a
912 separate nonlapsing account within the General Fund. The account
913 shall contain any moneys required by law to be deposited into the
914 account. Any balance remaining in said account at the end of any fiscal
915 year shall be carried forward in the account for the next fiscal year.

916 (b) [Three hundred forty-five] Five hundred thousand dollars of the
917 amount collected pursuant to section 19a-55, as amended, in each fiscal
918 year, shall be credited to the newborn screening account, and be
919 available for expenditure by the Department of Public Health for the
920 expenses of the testing required by sections 19a-55, as amended, and
921 19a-59.

922 Sec. 21. Section 17b-239 of the 2006 supplement to the general
923 statutes is repealed and the following is substituted in lieu thereof
924 (*Effective July 1, 2006*):

925 (a) The rate to be paid by the state to hospitals receiving
926 appropriations granted by the General Assembly and to freestanding
927 chronic disease hospitals, providing services to persons aided or cared
928 for by the state for routine services furnished to state patients, shall be

929 based upon reasonable cost to such hospital, or the charge to the
930 general public for ward services or the lowest charge for semiprivate
931 services if the hospital has no ward facilities, imposed by such
932 hospital, whichever is lowest, except to the extent, if any, that the
933 commissioner determines that a greater amount is appropriate in the
934 case of hospitals serving a disproportionate share of indigent patients.
935 Such rate shall be promulgated annually by the Commissioner of
936 Social Services. Nothing contained [herein] in this section shall
937 authorize a payment by the state for such services to any such hospital
938 in excess of the charges made by such hospital for comparable services
939 to the general public. Notwithstanding the provisions of this section,
940 for the rate period beginning July 1, 2000, rates paid to freestanding
941 chronic disease hospitals and freestanding psychiatric hospitals shall
942 be increased by three per cent. For the rate period beginning July 1,
943 2001, a freestanding chronic disease hospital or freestanding
944 psychiatric hospital shall receive a rate that is two and one-half per
945 cent more than the rate it received in the prior fiscal year and such rate
946 shall remain effective until December 31, 2002. Effective January 1,
947 2003, a freestanding chronic disease hospital or freestanding
948 psychiatric hospital shall receive a rate that is two per cent more than
949 the rate it received in the prior fiscal year. Notwithstanding the
950 provisions of this subsection, for the period commencing July 1, 2001,
951 and ending June 30, 2003, the commissioner may pay an additional
952 total of no more than three hundred thousand dollars annually for
953 services provided to long-term ventilator patients. For purposes of this
954 subsection, "long-term ventilator patient" means any patient at a
955 freestanding chronic disease hospital on a ventilator for a total of sixty
956 days or more in any consecutive twelve-month period. Effective July 1,
957 2004, each freestanding chronic disease hospital shall receive a rate
958 that is two per cent more than the rate it received in the prior fiscal
959 year.

960 (b) Effective October 1, 1991, the rate to be paid by the state for the
961 cost of special services rendered by such hospitals shall be established
962 annually by the commissioner for each such hospital based on the

963 reasonable cost to each hospital of such services furnished to state
964 patients. Nothing contained herein shall authorize a payment by the
965 state for such services to any such hospital in excess of the charges
966 made by such hospital for comparable services to the general public.

967 (c) The term "reasonable cost" as used in this section means the cost
968 of care furnished such patients by an efficient and economically
969 operated facility, computed in accordance with accepted principles of
970 hospital cost reimbursement. The commissioner may adjust the rate of
971 payment established under the provisions of this section for the year
972 during which services are furnished to reflect fluctuations in hospital
973 costs. Such adjustment may be made prospectively to cover anticipated
974 fluctuations or may be made retroactive to any date subsequent to the
975 date of the initial rate determination for such year or in such other
976 manner as may be determined by the commissioner. In determining
977 "reasonable cost" the commissioner may give due consideration to
978 allowances for fully or partially unpaid bills, reasonable costs
979 mandated by collective bargaining agreements with certified collective
980 bargaining agents or other agreements between the employer and
981 employees, provided "employees" shall not include persons employed
982 as managers or chief administrators, requirements for working capital
983 and cost of development of new services, including additions to and
984 replacement of facilities and equipment. The commissioner shall not
985 give consideration to amounts paid by the facilities to employees as
986 salary, or to attorneys or consultants as fees, where the responsibility
987 of the employees, attorneys or consultants is to persuade or seek to
988 persuade the other employees of the facility to support or oppose
989 unionization. Nothing in this subsection shall prohibit the
990 commissioner from considering amounts paid for legal counsel related
991 to the negotiation of collective bargaining agreements, the settlement
992 of grievances or normal administration of labor relations.

993 (d) The state shall also pay to such hospitals for each outpatient
994 clinic and emergency room visit a reasonable rate to be established
995 annually by the commissioner for each hospital, such rate to be
996 determined by the reasonable cost of such services. The emergency

997 room visit rates in effect June 30, 1991, shall remain in effect through
998 June 30, 1993, except those which would have been decreased effective
999 July 1, 1991, or July 1, 1992, shall be decreased. Nothing contained
1000 herein shall authorize a payment by the state for such services to any
1001 hospital in excess of the charges made by such hospital for comparable
1002 services to the general public. For those outpatient hospital services
1003 paid on the basis of a ratio of cost to charges, the ratios in effect June
1004 30, 1991, shall be reduced effective July 1, 1991, by the most recent
1005 annual increase in the consumer price index for medical care. For those
1006 outpatient hospital services paid on the basis of a ratio of cost to
1007 charges, the ratios computed to be effective July 1, 1994, shall be
1008 reduced by the most recent annual increase in the consumer price
1009 index for medical care. The emergency room visit rates in effect June
1010 30, 1994, shall remain in effect through December 31, 1994. The
1011 Commissioner of Social Services shall establish a fee schedule for
1012 outpatient hospital services to be effective on and after January 1, 1995.
1013 Except with respect to the rate periods beginning July 1, 1999, and July
1014 1, 2000, such fee schedule shall be adjusted annually beginning July 1,
1015 1996, to reflect necessary increases in the cost of services.
1016 Notwithstanding the provisions of this subsection, the fee schedule for
1017 the rate period beginning July 1, 2000, shall be increased by ten and
1018 one-half per cent, effective June 1, 2001. Notwithstanding the
1019 provisions of this subsection, outpatient rates in effect as of June 30,
1020 2003, shall remain in effect through June 30, 2005. Effective July 1, 2006,
1021 subject to available appropriations, the commissioner shall increase
1022 outpatient service fees for services that may include clinic, emergency
1023 room, magnetic resonance imaging, and computerized axial
1024 tomography. Not later than October 1, 2006, the commissioner shall
1025 submit a report, in accordance with section 11-4a, to the joint standing
1026 committees of the General Assembly having cognizance of matters
1027 relating to public health, human services and appropriations and the
1028 budgets of state agencies, identifying such fee increases and the
1029 associated cost increase estimates.

1030 (e) The commissioner shall adopt regulations, in accordance with

1031 the provisions of chapter 54, establishing criteria for defining
1032 emergency and nonemergency visits to hospital emergency rooms. All
1033 nonemergency visits to hospital emergency rooms shall be paid at the
1034 hospital's outpatient clinic services rate. Nothing contained in this
1035 subsection or the regulations adopted hereunder shall authorize a
1036 payment by the state for such services to any hospital in excess of the
1037 charges made by such hospital for comparable services to the general
1038 public.

1039 (f) On and after October 1, 1984, the state shall pay to an acute care
1040 general hospital for the inpatient care of a patient who no longer
1041 requires acute care a rate determined by the following schedule: For
1042 the first seven days following certification that the patient no longer
1043 requires acute care the state shall pay the hospital at a rate of fifty per
1044 cent of the hospital's actual cost; for the second seven-day period
1045 following certification that the patient no longer requires acute care the
1046 state shall pay seventy-five per cent of the hospital's actual cost; for the
1047 third seven-day period following certification that the patient no
1048 longer requires acute care and for any period of time thereafter, the
1049 state shall pay the hospital at a rate of one hundred per cent of the
1050 hospital's actual cost. On and after July 1, 1995, no payment shall be
1051 made by the state to an acute care general hospital for the inpatient
1052 care of a patient who no longer requires acute care and is eligible for
1053 Medicare unless the hospital does not obtain reimbursement from
1054 Medicare for that stay.

1055 (g) Effective June 1, 2001, the commissioner shall establish inpatient
1056 hospital rates in accordance with the method specified in regulations
1057 adopted pursuant to this section and applied for the rate period
1058 beginning October 1, 2000, except that the commissioner shall update
1059 each hospital's target amount per discharge to the actual allowable cost
1060 per discharge based upon the 1999 cost report filing multiplied by
1061 sixty-two and one-half per cent if such amount is higher than the target
1062 amount per discharge for the rate period beginning October 1, 2000, as
1063 adjusted for the ten per cent incentive identified in Section 4005 of
1064 Public Law 101-508. If a hospital's rate is increased pursuant to this

1065 subsection, the hospital shall not receive the ten per cent incentive
1066 identified in Section 4005 of Public Law 101-508. For rate periods
1067 beginning October 1, 2001, through [March 31, 2008] September 30,
1068 2006, the commissioner shall not apply an annual adjustment factor to
1069 the target amount per discharge. Effective April 1, 2005, the revised
1070 target amount per discharge for each hospital with a target amount per
1071 discharge less than three thousand seven hundred fifty dollars shall be
1072 three thousand seven hundred fifty dollars. [Effective October 1, 2006,
1073 the revised target amount per discharge for each hospital with a target
1074 amount per discharge less than four thousand dollars shall be four
1075 thousand dollars. Effective October 1, 2007, the revised target amount
1076 per discharge for each hospital with a target amount per discharge less
1077 than four thousand two hundred fifty dollars shall be four thousand
1078 two hundred fifty dollars.] Effective October 1, 2006, subject to
1079 available appropriations, the commissioner shall establish an increased
1080 target amount per discharge of not less than four thousand dollars for
1081 each hospital with a target amount per discharge less than four
1082 thousand dollars for the rate period ending September 30, 2006, and
1083 the commissioner may apply an annual adjustment factor to the target
1084 amount per discharge for hospitals that are not increased as a result of
1085 the revised target amount per discharge. Not later than October 1,
1086 2006, the commissioner shall submit a report, in accordance with
1087 section 11-4a, to the joint standing committees of the General
1088 Assembly having cognizance of matters relating to public health,
1089 human services and appropriations and the budgets of state agencies
1090 identifying the increased target amount per discharge and the
1091 associated cost increase estimates.

1092 Sec. 22. (*Effective July 1, 2006*) (a) The Department of Social Services,
1093 in consultation with the Connecticut Pharmacists Association, shall
1094 review the impact of the implementation of average manufacturer
1095 price reimbursement methodology that shall take effect on January 1,
1096 2007, as required under the federal Deficit Reduction Act of 2005. Such
1097 review shall include, but not be limited to, the financial impact of the
1098 required change in pharmacy reimbursement received under the

1099 Medicaid fee-for-service program and recommendations for potential
1100 changes in the dispensing fee, both for brand name drugs and generic
1101 drug products.

1102 (b) Based on the outcome of such study, on or after April 1, 2007,
1103 and for the fiscal year ending on June 30, 2007, the Department of
1104 Social Services may, subsequent to the approval by the Secretary of the
1105 Office of Policy and Management, implement increased adjustments to
1106 dispensing fees paid to licensed pharmacies pursuant to section 17b-
1107 280 of the 2006 supplement to the general statutes for prescription
1108 drugs dispensed to Medicaid, ConnPACE and Connecticut AIDS drug
1109 assistance recipients. The Department of Social Services may provide,
1110 upon approval by the Secretary of the Office of Policy and
1111 Management, increased adjustments to the dispensing fee paid to
1112 licensed pharmacies providing services to ConnPACE, Medicaid, state-
1113 administered general assistance and Connecticut AIDS drug assistance
1114 recipients in order to indemnify and hold harmless those pharmacies
1115 that experience financial hardship attributable to their participation in
1116 said state-funded programs due to the implementation of the average
1117 manufacturer price reimbursement methodology required under the
1118 federal Deficit Reduction Act of 2005.

1119 Sec. 23. (*Effective July 1, 2006*) The Children's Trust Fund Council
1120 and the Department of Children and Families shall enter into an
1121 agreement whereby the department shall transfer to the council six
1122 hundred fourteen thousand one hundred ten dollars appropriated to
1123 the department in house bill 5845 of the current session.

1124 Sec. 24. (*Effective July 1, 2006*) Subject to the provisions of section 3-
1125 125a of the general statutes, the Department of Social Services is
1126 authorized to use moneys in the Medicaid appropriation for the fiscal
1127 year ending June 30, 2007, to pay proceeds of any settlement
1128 agreement in the action of Mary Carr, et al v. Patricia Wilson-Coker,
1129 Commissioner of the Department of Social Services, United States
1130 District Court, District of Connecticut, Civil Action No. 3: 00CV1050
1131 (AVC) to comply with such agreement. The department shall, not later

1132 than six months from the date of such settlement, report to the joint
1133 standing committees of the General Assembly having cognizance of
1134 matters relating to appropriations and the budgets of state agencies,
1135 human services and public health on a plan to achieve compliance
1136 with such settlement.

1137 Sec. 25. Section 5-239a of the general statutes is repealed and the
1138 following is substituted in lieu thereof (*Effective July 1, 2006*):

1139 The Commissioner of Administrative Services may establish
1140 procedures for the assignment of permanent state employees of the
1141 executive branch, including institutions of higher education
1142 encompassing technical and junior colleges as well as four-year
1143 colleges and universities, to a federal agency, to the office of the court
1144 monitor at the Department of Children and Families established in
1145 accordance with the terms of the consent decree entered in the case of
1146 Juan F. v. O'Neill, United States District Court, Docket No. H-89-859
1147 (D. Conn. January 7, 1991), to any municipality of the state or to
1148 institutions of higher education, including private as well as public
1149 institutions and technical and junior colleges as well as four-year
1150 colleges and universities, provided that the assignment meets with the
1151 written approval of the appointing authorities of the agencies and
1152 institutions involved in the assignment of the employee. State
1153 employees may only be assigned to such agencies and institutions with
1154 their personal consent. Assignments may be made for a period of up to
1155 two years and renewed once for an additional two years, provided any
1156 assignment of an employee to the court monitor at the Department of
1157 Children and Families shall not be subject to such durational time
1158 limits and may remain effective until December 31, [2006] 2007. An
1159 employee on such assignment may be deemed to be on detail to a
1160 regular work assignment of his or her agency or institution and
1161 entitled to full salary and benefits and all rights and privileges for his
1162 class or position. Employees of a federal agency or any municipality of
1163 the state or institutions of higher education, including private as well
1164 as public institutions and technical and junior colleges as well as four-
1165 year colleges and universities, on assignment with an agency of the

1166 executive branch of state government shall serve under appointment
1167 made without regard to provisions of the general statutes regarding
1168 appointment in the classified service. The cost of any salary and
1169 benefits may be shared by the jurisdiction or be paid entirely by one or
1170 the other and shall be subject to negotiation between the agencies or
1171 institutions cooperating on the assignment. Once the agencies or
1172 institutions have agreed upon the assignment and all terms and
1173 conditions for the assignment, it shall be put into effect by a written
1174 agreement and submitted to the Commissioner of Administrative
1175 Services and the Secretary of the Office of Policy and Management for
1176 approval.

1177 Sec. 26. Subdivision (9) of subsection (a) of section 10-76d of the 2006
1178 supplement to the general statutes is repealed and the following is
1179 substituted in lieu thereof (*Effective July 1, 2006*):

1180 (9) [For] Notwithstanding any provision of the general statutes, for
1181 purposes of Medicaid reimbursement, when recommended by the
1182 planning and placement team and specified on the individualized
1183 education program, a service eligible for reimbursement under the
1184 Medicaid program shall be deemed to be authorized by a practitioner
1185 of the healing arts under 42 CFR 440.130, provided such service is
1186 recommended by an appropriately licensed or certified individual and
1187 is within the individual's scope of practice. Certain items of durable
1188 medical equipment, recommended pursuant to the provisions of this
1189 subdivision, may be subject to prior authorization requirements
1190 established by the Commissioner of Social Services. Diagnostic and
1191 evaluation services eligible for reimbursement under the Medicaid
1192 program [.] and recommended by the planning and placement team
1193 [and specified on the individualized education program] shall also be
1194 deemed to be authorized by a practitioner of the healing arts under 42
1195 CFR 440.130 provided such services are recommended by an
1196 appropriately licensed or certified individual and are within the
1197 individual's scope of practice.

1198 Sec. 27. Subsection (a) of section 17b-597 of the general statutes is

1199 repealed and the following is substituted in lieu thereof (*Effective July*
1200 *1, 2006*):

1201 (a) The Department of Social Services shall establish and implement
1202 a working persons with disabilities program to provide medical
1203 assistance as authorized under [Section 201(a)(1) of Public Law 106-
1204 170] 42 USC 1396a(a)(10)(A)(ii), as amended from time to time, to
1205 persons who are disabled and regularly employed.

1206 Sec. 28. Subsection (b) of section 17a-22j of the 2006 supplement to
1207 the general statutes is repealed and the following is substituted in lieu
1208 thereof (*Effective October 1, 2006*):

1209 (b) The council shall consist of the following members:

1210 (1) The chairpersons and ranking members of the joint standing
1211 committees of the General Assembly having cognizance of matters
1212 relating to human services, public health, appropriations and the
1213 budgets of state agencies, or their designees;

1214 (2) A member of the Community Mental Health Strategy Board,
1215 established pursuant to section 17a-485b, as selected by said board;

1216 (3) The Commissioner of Mental Health and Addiction Services, or
1217 said commissioner's designee;

1218 (4) Sixteen members appointed by the chairpersons of the advisory
1219 council on Medicaid managed care, established pursuant to section
1220 17b-28;

1221 (A) Two of whom are representatives of general or specialty
1222 psychiatric hospitals;

1223 (B) One of whom is an adult with a psychiatric disability;

1224 (C) One of whom is an advocate for adults with psychiatric
1225 disabilities;

1226 (D) Two of whom are parents of children who have a behavioral

- 1227 health disorder or have received child protection or juvenile justice
1228 services from the Department of Children and Families;
- 1229 (E) One of whom has expertise in health policy and evaluation;
- 1230 (F) One of whom is an advocate for children with behavioral health
1231 disorders;
- 1232 (G) One of whom is a primary care provider serving HUSKY
1233 children;
- 1234 (H) One of whom is a child psychiatrist serving HUSKY children;
- 1235 (I) One of whom is either an adult with a substance use disorder or
1236 an advocate for adults with substance use disorders;
- 1237 (J) One of whom is a representative of school-based health clinics;
- 1238 (K) One of whom is a provider of community-based behavioral
1239 health services for adults;
- 1240 (L) One of whom is a provider of residential treatment for children;
- 1241 (M) One of whom is a provider of community-based services for
1242 children with behavioral health problems; and
- 1243 (N) One of whom is a member of the advisory council on Medicaid
1244 managed care;
- 1245 (5) ~~[Four]~~ Seven nonvoting ex-officio members, one each appointed
1246 by the Commissioners of Social Services, Children and Families [and]
1247 Mental Health and Addiction Services and Education to represent his
1248 or her department and one appointed by the State Comptroller, the
1249 Secretary of the Office of Policy and Management and the Office of
1250 Health Care Access to represent said [department] offices; [and]
- 1251 (6) One or more consumers appointed by the chairpersons of the
1252 council, to be nonvoting ex-officio members; and

1253 [(6)] (7) One representative from the administrative services
1254 organization and from each Medicaid managed care organization, to
1255 be nonvoting ex-officio members.

1256 Sec. 29. Subsection (c) of section 17a-22j of the 2006 supplement to
1257 the general statutes is repealed and the following is substituted in lieu
1258 thereof (*Effective October 1, 2006*):

1259 (c) All appointments to the council shall be made no later than July
1260 1, 2005, except that the chairpersons of the council may appoint
1261 additional consumers to the council as nonvoting ex-officio members.
1262 Any vacancy shall be filled by the appointing authority.

1263 Sec. 30. Section 17a-22l of the 2006 supplement to the general
1264 statutes is repealed and the following is substituted in lieu thereof
1265 (*Effective October 1, 2006*):

1266 The Departments of Children and Families and Social Services shall
1267 develop consumer [grievance] and provider appeal procedures and
1268 shall submit such procedures to the Behavioral Health Partnership
1269 Oversight Council for review and comment. Such procedures shall
1270 include, but not be limited to, procedures for a consumer or any
1271 provider acting on behalf of a consumer to appeal a denial or
1272 determination. The Departments of Children and Families and Social
1273 Services shall establish time frames for appealing decisions made by
1274 the administrative services organization, including an expedited
1275 review in emergency situations. Any procedure for appeals shall
1276 require that an appeal be heard not later than thirty days after such
1277 appeal is filed and shall be decided not later than forty-five days after
1278 such appeal is filed.

1279 Sec. 31. (NEW) (*Effective July 1, 2006*) (a) On or before October 1,
1280 2007, the Commissioner of Mental Health and Addiction Services,
1281 within available appropriations set forth in section 52 of this act and in
1282 consultation with the Community Mental Health Strategy Board
1283 established under section 17a-485b of the general statutes, shall
1284 establish and implement (1) a pilot program for general pediatric,

1285 family medicine and geriatric health care professionals to improve
1286 their ability to identify, diagnose, refer and treat patients with mental
1287 illness, and (2) a pilot program of peer-counseling in the Division of
1288 the State Police.

1289 (b) On or before January 1, 2009, the Commissioner of Mental
1290 Health and Addiction Services shall evaluate the pilot programs
1291 established under subsection (a) of this section and shall submit a
1292 report of the commissioner's findings and recommendations to the
1293 joint standing committee of the General Assembly having cognizance
1294 of matters relating to public health, in accordance with the provisions
1295 of section 11-4a of the general statutes.

1296 Sec. 32. (NEW) (*Effective from passage*) (a) The Department of Social
1297 Services, in consultation with the Department of Mental Health and
1298 Addiction Services and the Community Mental Health Strategy Board
1299 established under section 17a-485b of the general statutes, may seek
1300 approval of an amendment to the state Medicaid plan or a waiver from
1301 federal law, whichever is sufficient and most expeditious, to establish
1302 and implement a Medicaid-financed home and community-based
1303 program to provide community-based services and, if necessary,
1304 housing assistance, to adults with severe and persistent psychiatric
1305 disabilities being discharged or diverted from nursing home
1306 residential care.

1307 (b) On or before January 1, 2007, and annually thereafter, the
1308 Commissioner of Social Services, in consultation with the
1309 Commissioner of Mental Health and Addiction Services, shall submit a
1310 report to the joint standing committee of the General Assembly having
1311 cognizance of matters relating to public health, in accordance with the
1312 provisions of section 11-4a of the general statutes, on the status of any
1313 amendment to the state Medicaid plan or waiver from federal law
1314 pursuant to subsection (a) of this section and on the establishment and
1315 implementation of the program authorized under said subsection (a).

1316 Sec. 33. Subdivision (12) of subsection (a) of section 38a-226c of the

1317 2006 supplement to the general statutes is repealed and the following
1318 is substituted in lieu thereof (*Effective October 1, 2006*):

1319 (12) Each utilization review company shall annually file with the
1320 commissioner;

1321 (A) [the] The names of all managed care organizations, as defined in
1322 section 38a-478, as amended, that the utilization review company
1323 services in Connecticut; [,]

1324 (B) [any] Any utilization review services for which the utilization
1325 review company has contracted out for services and the name of such
1326 company providing the services; [, and]

1327 (C) [the] The number of utilization review determinations not to
1328 certify an admission, service, procedure or extension of stay and the
1329 outcome of such determination upon appeal within the utilization
1330 review company. Determinations related to mental or nervous
1331 conditions, as defined in section 38a-514, shall be reported separately
1332 from all other determinations reported under this subdivision; and

1333 (D) The following information relative to requests for utilization
1334 review of mental health services for enrollees of fully insured health
1335 benefit plans or self-insured or self-funded employee health benefit
1336 plans, separately and by category: (i) The reason for the request,
1337 including, but not limited to, an inpatient admission, service,
1338 procedure or extension of inpatient stay or an outpatient treatment, (ii)
1339 the number of requests denied by type of request, and (iii) whether the
1340 request was denied or partially denied.

1341 Sec. 34. Section 38a-478~~l~~ of the general statutes is repealed and the
1342 following is substituted in lieu thereof (*Effective October 1, 2006*):

1343 (a) Not later than March 15, 1999, and annually thereafter, the
1344 Insurance Commissioner, after consultation with the Commissioner of
1345 Public Health, shall develop and distribute a consumer report card on
1346 all managed care organizations. The commissioner shall develop the

1347 consumer report card in a manner permitting consumer comparison
1348 across organizations.

1349 (b) The consumer report card shall include (1) all health care centers
1350 licensed pursuant to chapter 698a, [and] (2) the fifteen largest licensed
1351 health insurers that use provider networks and that are not included in
1352 subdivision (1) of this subsection, and (3) information concerning
1353 mental health services, as specified in subsection (c) of this section. The
1354 insurers selected pursuant to subdivision (2) of this subsection shall be
1355 selected on the basis of Connecticut direct written health premiums
1356 from such network plans.

1357 (c) With respect to mental health services, the consumer report card
1358 shall include information or measures with respect to the percentage of
1359 enrollees receiving mental health services, utilization of mental health
1360 and chemical dependence services, inpatient and outpatient
1361 admissions, discharge rates and average lengths of stay. Such data
1362 shall be collected in a manner consistent with the Natural Committee
1363 for Quality Assurance Health Plan Employer Data and Information Set
1364 (HEDIS) measures.

1365 [(c)] (d) The commissioner shall test market a draft of the consumer
1366 report card prior to its publication and distribution. As a result of such
1367 test marketing, the commissioner may make any necessary
1368 modification to its form or substance.

1369 Sec. 35. (NEW) (*Effective October 1, 2006*) The Insurance
1370 Commissioner shall provide written notification to each insurance
1371 company, fraternal benefit society, hospital service corporation,
1372 medical service corporation, health care center or any other entity that
1373 delivers or issues for delivery, in this state, any individual or group
1374 health insurance plan (1) of any benefits required to be provided in
1375 such plan pursuant to chapter 700c of the general statutes, or of any
1376 modification to such benefits on or after October 1, 2006, at least thirty
1377 days prior to the date such benefits or modification becomes effective,
1378 and (2) instructing such company, society, corporation, center or other

1379 entity to submit to the Insurance Commissioner, prior to the date such
1380 benefits or modification becomes effective or upon the renewal date of
1381 the plan, any necessary policy forms, in accordance with the provisions
1382 of section 38a-481 or 38a-513 of the general statutes, as applicable, that
1383 reflect such benefits or modification.

1384 Sec. 36. (*Effective July 1, 2006*) Funds appropriated to the Department
1385 of Mental Health and Addiction Services, from the General Fund, for
1386 the fiscal year ending June 30, 2007, for purposes of the Community
1387 Mental Health Strategy Board, may, upon the recommendation of the
1388 Community Mental Health Strategy Board established under section
1389 17a-485b of the general statutes and with the approval of the Secretary
1390 of the Office of Policy and Management, be expended for the purpose
1391 of providing services and programs that result in maximization of
1392 federal Medicaid reimbursement for community-based mental health
1393 care and a reduction in inappropriate emergency hospitalization,
1394 inpatient psychiatric care, nursing home admission, incarceration or
1395 referral to juvenile justice and other institutionalization of adults and
1396 children with serious mental illness. Such services and programs may
1397 include, but shall not be limited to, (1) housing support to participants
1398 in the program authorized by section 32 of this act, and (2)
1399 consultations with mental health professionals for early care and
1400 education providers.

1401 Sec. 37. (NEW) (*Effective July 1, 2006*) (a) The Commissioner of
1402 Mental Retardation, in consultation with the Commissioners of Social
1403 Services and Mental Health and Addiction Services and any other
1404 commissioner the Commissioner of Mental Retardation deems
1405 appropriate, shall establish a pilot autism spectrum disorders program,
1406 to provide a coordinated system of supports and services, including
1407 case management, for persons with autism spectrum disorders who do
1408 not have mental retardation, as defined in section 1-1g of the general
1409 statutes, and their families. The pilot program shall serve up to fifty
1410 adults with autism spectrum disorders who are not eligible for services
1411 from the Department of Mental Retardation under chapter 319b of the
1412 general statutes.

1413 (b) The Commissioner of Mental Retardation shall establish
1414 eligibility requirements for participation in the program.

1415 (c) The Commissioner of Mental Retardation, or the commissioner's
1416 designee, shall identify appropriate individualized services and
1417 supports for each person in the program and the family of each person
1418 in the program and shall coordinate the provision of such services and
1419 supports to such person and family.

1420 (d) The pilot program shall commence on or before October 1, 2006,
1421 and shall terminate not later than October 1, 2008.

1422 (e) The Commissioner of Mental Retardation shall report, in
1423 accordance with section 11-4a of the general statutes, to the joint
1424 standing committee of the General Assembly having cognizance of
1425 matters relating to public health not later than January 1, 2009,
1426 concerning the results of such pilot program. The report shall include,
1427 recommendations concerning a system for addressing the needs of
1428 persons with autism spectrum disorder, including, but not limited to,
1429 recommendations (1) establishing an independent council to advise the
1430 Department of Mental Retardation with respect to system design,
1431 implementation and quality enhancement, (2) establishing procedural
1432 safeguards, (3) designing and implementing a quality enhancement
1433 and improvement process, and (4) designing and implementing an
1434 interagency data and information management system.

1435 Sec. 38. Section 1 of special act 02-7 is amended to read as follows
1436 (*Effective July 1, 2006*):

1437 [The Office of Policy and Management shall conduct] The General
1438 Assembly, after consultation with the Commission on Aging, the
1439 Long-Term Care Advisory Council and the Long-Term Care Planning
1440 Committee, shall contract for a comprehensive needs assessment of the
1441 unmet long-term care needs in the state and project future demand for
1442 [such] services. Such assessment shall include, [a review of the
1443 Department of Mental Retardation's waiting list] but not be limited to,
1444 a review and evaluation of: (1) The number of persons presently at risk

1445 for having unmet long-term care needs, (2) the number of persons
1446 potentially at risk for having long-term care needs over the course of
1447 the next thirty years, (3) both costs and public and private resources
1448 available to meet long-term care needs, including the adequacy of
1449 current resources, projected costs and the projected resources needed
1450 to address long-term care needs over the next thirty years, (4) the
1451 existing array of services available to persons with long-term care
1452 needs, (5) existing and potential future models of public and private
1453 service delivery systems for persons with long-term care needs, (6)
1454 state government's programmatic structure in meeting the needs of
1455 persons requiring long-term care, (7) strategies that may assist families
1456 in making provisions for their own long-term care needs at reasonable
1457 costs, and (8) the service needs of the state's elderly population with
1458 long-term care needs with emphasis on healthcare, housing,
1459 transportation, nutrition, employment, prevention and recreation
1460 services. Such assessment shall also include recommendations on
1461 qualitative and quantitative changes that should be made to existing
1462 programs or service delivery systems, including recommendations on
1463 new programs or service delivery systems to better serve persons with
1464 long-term care needs.

1465 Sec. 39. Section 12-818 of the general statutes is repealed and the
1466 following is substituted in lieu thereof (*Effective July 1, 2006*):

1467 For the fiscal year ending June 30, 2000, the Connecticut Lottery
1468 Corporation shall transfer the sum of eight hundred seventy-five
1469 thousand dollars of the revenue received from the sale of lottery tickets
1470 to the chronic gamblers treatment and rehabilitation account created
1471 pursuant to section 17a-713. For [the fiscal year ending June 30, 2001,
1472 and each fiscal year thereafter] each of the fiscal years ending June 30,
1473 2001, to June 30, 2006, inclusive, the Connecticut Lottery Corporation
1474 shall transfer the sum of one million two hundred thousand dollars of
1475 the revenue received from the sale of lottery tickets to the chronic
1476 gamblers treatment and rehabilitation account created pursuant to
1477 section 17a-713. For the fiscal year ending June 30, 2007, and each
1478 fiscal year thereafter, the Connecticut Lottery Corporation shall

1479 transfer one million five hundred thousand dollars of the revenue
1480 received from the sale of lottery tickets to the chronic gamblers
1481 treatment rehabilitation account created pursuant to section 17a-713.

1482 Sec. 40. Section 55 of public act 05-280 is repealed and the following
1483 is substituted in lieu thereof (*Effective from passage*):

1484 [During] For the fiscal [year] years ending June 30, 2006, and June
1485 30, 2007, the Commissioner of Social Services shall, within existing
1486 budgetary resources, [in an amount not to exceed one hundred
1487 thousand dollars,] provide grants not to exceed [twenty-five] fifty
1488 thousand dollars over the two-year period for each grant, to four
1489 municipalities with populations of twenty-five thousand or more, or to
1490 a nonprofit organization located within any such municipality. Such
1491 grants shall be used by such municipality or nonprofit organization to
1492 develop and plan financially self-sustaining community-based regional
1493 transportation systems that, through a combination of private
1494 donations and user fees, provide transportation services on behalf of
1495 elderly persons. Prior to the disbursement of any grant made pursuant
1496 to this section, a municipality selected to receive such grant shall
1497 demonstrate to the satisfaction of the commissioner, that such
1498 municipality has secured additional private funds, in an amount of not
1499 less than twenty-five thousand dollars that shall be used to develop
1500 and plan financially self-sustaining community-based regional
1501 transportation systems. Any municipality selected to receive a grant
1502 pursuant to this section shall, to the extent practicable, model such
1503 community-based regional transportation system on the ITNAmerica
1504 model and shall work cooperatively with the regional planning agency
1505 of which the municipality is a member in planning and developing
1506 such community-based regional transportation system.

1507 Sec. 41. (*Effective from passage*) The unexpended balance of funds
1508 appropriated to the Department of Social Services for the provision of
1509 grants to be used in the development and implementation of self-
1510 sustaining community-based regional transportation systems,
1511 pursuant to section 55 of public act 05-280, shall not lapse on June 30,

1512 2006, and such funds shall continue to be available for expenditure
1513 during the fiscal year ending on June 30, 2007.

1514 Sec. 42. (*Effective from passage*) (a) There is established a Families
1515 With Service Needs Advisory Board. The board shall consist of the
1516 following members: (1) Two representatives of the Department of
1517 Children and Families, appointed by the Commissioner of Children
1518 and Families, one of whom shall be a representative from the division
1519 of said department that provides juvenile justice services and one of
1520 whom shall be a representative of said department who is responsible
1521 for providing services to girls; (2) the Chief Court Administrator, or the
1522 Chief Court Administrator's designee; (3) a judge of the Superior Court
1523 assigned to hear juvenile matters, appointed by the Chief Justice; (4) a
1524 public defender, assistant public defender or deputy assistant public
1525 defender specializing in cases involving families with service needs,
1526 appointed by the Chief Public Defender; (5) the Child Advocate, or the
1527 Child Advocate's designee; (6) the Chief Child Protection Attorney, or
1528 the Chief Child Protection Attorney's designee; (7) the Chief State's
1529 Attorney, or the Chief State's Attorney's designee; (8) the Secretary of
1530 the Office of Policy and Management, or the secretary's designee; (9)
1531 the chairpersons and ranking members of the joint standing
1532 committees of the General Assembly having cognizance of matters
1533 relating to the judiciary and human services, or their designees; (10)
1534 one member appointed by the Governor; and (11) two members to
1535 serve as chairpersons of the board, one of whom shall be appointed by
1536 the speaker of the House of Representatives and one of whom shall be
1537 appointed by the president pro tempore of the Senate. All
1538 appointments to the board shall be made not later than thirty days
1539 after the effective date of this section. Any vacancy shall be filled by
1540 the appointing authority. The chairpersons of the board shall schedule
1541 the first meeting of the board, which shall be held not later than sixty
1542 days after the effective date of this section.

1543 (b) The Families With Service Needs Advisory Board shall (1)
1544 monitor the progress being made by the Department of Children and
1545 Families in developing services and programming for girls from

1546 families with service needs and other girls, (2) monitor the progress
1547 being made by the Judicial Department in the implementation of the
1548 requirements of public act 05-250, (3) provide advice with respect to
1549 such implementation upon the request of the Judicial Department or
1550 the General Assembly, and (4) not later than December 31, 2007, make
1551 written recommendations to the Judicial Department and the General
1552 Assembly, in accordance with the provisions of section 11-4a of the
1553 general statutes, with respect to the accomplishment of such
1554 implementation by the effective date of public act 05-250. The board
1555 shall terminate on December 31, 2007.

1556 Sec. 43. (*Effective from passage*) (a) Notwithstanding the provisions of
1557 subsection (l) of section 46b-129 of the general statutes, no person who
1558 as a child or youth, was the beneficiary of payments made for his or
1559 her care and maintenance, shall be liable to the state for repayment of
1560 the cost of such care and maintenance, if such person subsequently
1561 becomes entitled to the proceeds of a cause of action or insurance
1562 payments based upon the death of a minor child, occurring on or after
1563 June 25, 2005, but not later than the effective date of this section.

1564 (b) Notwithstanding the provisions of subsection (a) of section 46b-
1565 130 of the general statutes, no person who as a child or youth was the
1566 beneficiary of payments made for his or her care and maintenance,
1567 shall be liable to the state for repayment of the cost of such care and
1568 maintenance, if such person subsequently becomes entitled to the
1569 proceeds of a cause of action or insurance payments based upon the
1570 death of a minor child, occurring on or after June 25, 2005, but not later
1571 than the effective date of this section.

1572 Sec. 44. (NEW) (*Effective July 1, 2006*) The Commissioner of Social
1573 Services, pursuant to Section 6071 of the Deficit Reduction Act of 2005,
1574 may submit an application to the Secretary of Health and Human
1575 Services to establish a Money Follows the Person demonstration
1576 project. In the event the state is selected to participate in the
1577 demonstration project and the Department of Social Services elects to
1578 participate in such project, such project shall serve not more than one

1579 hundred persons and shall be designed to achieve the objectives set
1580 forth in Section 6071(a) of the Deficit Reduction Act of 2005. Services
1581 available under the demonstration project shall include, but not be
1582 limited to, personal care assistance services. The commissioner may
1583 apply for a Medicaid research and demonstration waiver under
1584 Section 1115 of the Social Security Act, if such waiver is necessary to
1585 implement the demonstration project. The commissioner may, if
1586 necessary, modify any existing Medicaid home or community-based
1587 waiver if such modification is required to implement the
1588 demonstration project.

1589 Sec. 45. (*Effective from passage*) Commencing on July 1, 2006, and
1590 quarterly thereafter, the Commissioner of Social Services, in
1591 consultation with the Labor Commissioner and the Secretary of the
1592 Office of Policy and Management, shall provide to the joint standing
1593 committees of the General Assembly having cognizance of matters
1594 relating to human services and appropriations and the budgets of state
1595 agencies and to the council established pursuant to section 17b-29 of
1596 the general statutes, status reports on the implementation of programs
1597 operated by said departments and included as part of the budget for
1598 the fiscal year ending on June 30, 2007, that are intended to bring the
1599 state into compliance with new federal requirements set forth in the
1600 federal Deficit Reduction Act of 2005 concerning the operation of the
1601 temporary assistance for needy families program. Such status reports
1602 shall contain a description of mechanisms that are currently being
1603 utilized, or contemplated to be utilized, by said departments to
1604 measure the outcomes and effects of programmatic revisions on
1605 program beneficiaries, enacted to effectuate the requirements of the
1606 federal Deficit Reduction Act of 2005. Programmatic revisions
1607 implemented by said departments to comply with the requirements of
1608 the federal Deficit Reduction Act of 2005 shall, to the extent permitted
1609 by federal law, emphasize vocational and educational training
1610 programs, work experience programs and the expansion of
1611 employment services and child care services. Such revisions shall be
1612 designed to promote the employment of participants in a manner

1613 consistent with the work participation rates required by federal law.

1614 Sec. 46. Subsections (a) and (b) of section 17b-28 of the general
1615 statutes are repealed and the following is substituted in lieu thereof
1616 (*Effective July 1, 2006*):

1617 (a) There is established a council which shall advise the
1618 Commissioner of Social Services on the planning and implementation
1619 of a system of Medicaid managed care and shall monitor such
1620 planning and implementation and shall advise the Waiver Application
1621 Development Council, established pursuant to section 17b-28a, on
1622 matters including, but not limited to, eligibility standards, benefits,
1623 access and quality assurance. The council shall be composed of the
1624 chairpersons and ranking members of the joint standing committees of
1625 the General Assembly having cognizance of matters relating to human
1626 services, [and] public health and appropriations and the budgets of
1627 state agencies, or their designees; two members of the General
1628 Assembly, one to be appointed by the president pro tempore of the
1629 Senate and one to be appointed by the speaker of the House of
1630 Representatives; the director of the Commission on Aging, or a
1631 designee; the director of the Commission on Children, or a designee;
1632 two community providers of health care, to be appointed by the
1633 president pro tempore of the Senate; two representatives of the
1634 insurance industry, to be appointed by the speaker of the House of
1635 Representatives; two advocates for persons receiving Medicaid, one to
1636 be appointed by the majority leader of the Senate and one to be
1637 appointed by the minority leader of the Senate; one advocate for
1638 persons with substance abuse disabilities, to be appointed by the
1639 majority leader of the House of Representatives; one advocate for
1640 persons with psychiatric disabilities, to be appointed by the minority
1641 leader of the House of Representatives; two advocates for the
1642 Department of Children and Families foster families, one to be
1643 appointed by the president pro tempore of the Senate and one to be
1644 appointed by the speaker of the House of Representatives; two
1645 members of the public who are currently recipients of Medicaid, one to
1646 be appointed by the majority leader of the House of Representatives

1647 and one to be appointed by the minority leader of the House of
1648 Representatives; two representatives of the Department of Social
1649 Services, to be appointed by the Commissioner of Social Services; two
1650 representatives of the Department of Public Health, to be appointed by
1651 the Commissioner of Public Health; two representatives of the
1652 Department of Mental Health and Addiction Services, to be appointed
1653 by the Commissioner of Mental Health and Addiction Services; two
1654 representatives of the Department of Children and Families, to be
1655 appointed by the Commissioner of Children and Families; two
1656 representatives of the Office of Policy and Management, to be
1657 appointed by the Secretary of the Office of Policy and Management;
1658 one representative of the office of the State Comptroller, to be
1659 appointed by the State Comptroller and the members of the Health
1660 Care Access Board who shall be ex-officio members and who may not
1661 designate persons to serve in their place. The council shall choose a
1662 chair from among its members. The joint committee on Legislative
1663 Management shall provide administrative support to such chair. The
1664 council shall convene its first meeting no later than June 1, 1994.

1665 (b) The council shall make recommendations concerning (1)
1666 guaranteed access to enrollees and effective outreach and client
1667 education; (2) available services comparable to those already in the
1668 Medicaid state plan, including those guaranteed under the federal
1669 Early and Periodic Screening, Diagnostic and Treatment Services
1670 Program under 42 USC 1396d; (3) the sufficiency of provider networks;
1671 (4) the sufficiency of capitated rates provider payments, financing and
1672 staff resources to guarantee timely access to services; (5) participation
1673 in managed care by existing community Medicaid providers; (6) the
1674 linguistic and cultural competency of providers and other program
1675 facilitators; (7) quality assurance; (8) timely, accessible and effective
1676 client grievance procedures; (9) coordination of the Medicaid managed
1677 care plan with state and federal health care reforms; (10) eligibility
1678 levels for inclusion in the program; (11) cost-sharing provisions; (12) a
1679 benefit package; (13) coordination with coverage under the HUSKY
1680 Plan, Part B; (14) the need for program quality studies within the areas

1681 identified in this section and the department's application for available
1682 grant funds for such studies; [and] (15) managed care portion of the
1683 state-administered general assistance program; and (16) other issues
1684 pertaining to the development of a Medicaid Research and
1685 Demonstration Waiver under Section 1115 of the Social Security Act.

1686 Sec. 47. (NEW) (*Effective from passage*) On or after January 1, 2007,
1687 and within any available federal or private funds, the Commissioner of
1688 Public Health, in consultation with the Medicaid managed care
1689 organizations administering the HUSKY Plan, Part A, as defined in
1690 section 17b-290 of the 2006 supplement to the general statutes, may
1691 establish a medical home pilot program in one region of the state to be
1692 determined by said commissioner in order to enhance health outcomes
1693 for children, including children with special health care needs, by
1694 ensuring that each child has a primary care physician who will provide
1695 continuous comprehensive health care for such child. Said
1696 commissioner may solicit and accept private funds to implement such
1697 pilot program.

1698 Sec. 48. (*Effective October 1, 2006*) Not later than one year following
1699 the establishment of the medical home pilot program under section 47
1700 of this act, the Commissioner of Public Health, shall evaluate such pilot
1701 program to ascertain specific improved health outcomes and any cost
1702 efficiencies achieved. Not later than thirty days following such
1703 evaluation, the Commissioner of Public Health shall submit a report, in
1704 accordance with section 11-4a of the general statutes, to the joint
1705 standing committees of the General Assembly having cognizance of
1706 matters relating to public health and appropriations and the budgets of
1707 state agencies on the evaluation of such pilot program.

1708 Sec. 49. Section 17b-261 of the 2006 supplement to the general
1709 statutes is amended by adding subsection (j) as follows (*Effective July 1,*
1710 *2006*):

1711 (NEW) (j) The Commissioner of Social Services shall provide Early
1712 and Periodic, Screening, Diagnostic and Treatment program services,

1713 as required by 42 USC 1396a(a)(43), 42 USC 1396d(r) and 42 USC
1714 1396d(a)(4)(B) and applicable federal regulations to all persons who
1715 are under the age of twenty-one and otherwise eligible for medical
1716 assistance under this section.

1717 Sec. 50. (NEW) (*Effective July 1, 2006*) The Commissioner of Social
1718 Services shall provide reimbursement under the Medicaid program to
1719 children for services provided by a home health care agency, as
1720 defined in section 19a-490 of the 2006 supplement to the general
1721 statutes, in the child's home or a substantially equivalent environment.
1722 For purposes of such reimbursement, a substantially equivalent
1723 environment may include, but not be limited to, facilities that provide
1724 child day care services, as defined in subsection (a) of section 19a-77 of
1725 the 2006 supplement to the general statutes, and after school programs,
1726 as defined in section 10-16x of the 2006 supplement to the general
1727 statutes.

1728 Sec. 51. (*Effective July 1, 2006*) The sum of \$50,000 appropriated to
1729 the Department of Public Health, from the General Fund, for the fiscal
1730 year ending June 30, 2007, for community health services, shall be
1731 transferred to other expenses.

1732 Sec. 52. (*Effective July 1, 2006*) The sum of two hundred seventy-five
1733 thousand dollars of the amount appropriated to the Department of
1734 Mental Health and Addiction Services in section 8 of house bill 5845 of
1735 the current session, for purposes of the Community Mental Health
1736 Strategy Board, shall be expended for the purposes of establishing and
1737 implementing the pilot programs authorized by section 31 of this act.

1738 Sec. 53. (*Effective July 1, 2006*) Up to the sum of one million seven
1739 hundred twenty-five thousand dollars of the amount appropriated to
1740 the Department of Mental Health and Addiction Services in section 8
1741 of house bill 5845 of the current session, for purposes of the
1742 Community Mental Health Strategy Board, shall be expended for the
1743 purposes of establishing and implementing the Medicaid-financed
1744 home and community-based program authorized by section 32 of this

1745 act.

1746 Sec. 54. Section 17a-317 of the 2006 supplement to the general
1747 statutes shall take effect July 1, 2007. (*Effective from passage*)

1748 Sec. 55. Section 17b-255 of the general statutes is repealed. (*Effective*
1749 *from passage*)"

This act shall take effect as follows and shall amend the following sections:		
Section 1	July 1, 2006	17b-340(a)
Sec. 2	July 1, 2006	17b-340(f)(4)
Sec. 3	July 1, 2006	17b-340(f)(16)
Sec. 4	July 1, 2006	17b-340(g)
Sec. 5	July 1, 2006	17b-340(h)(1)
Sec. 6	July 1, 2006	17b-321(a)
Sec. 7	July 1, 2006	17b-321(b)
Sec. 8	July 1, 2006	17b-605a
Sec. 9	July 1, 2006	17b-342a(a)
Sec. 10	July 1, 2006	New section
Sec. 11	July 1, 2006	17b-490(b)
Sec. 12	July 1, 2006	17b-363b
Sec. 13	July 1, 2006	17b-265e
Sec. 14	from passage	17b-256
Sec. 15	July 1, 2006	17b-242a
Sec. 16	July 1, 2006	17b-292(j)
Sec. 17	July 1, 2006	17b-84
Sec. 18	July 1, 2006	17b-131
Sec. 19	July 1, 2006	17b-264
Sec. 20	July 1, 2006	19a-55a
Sec. 21	July 1, 2006	17b-239
Sec. 22	July 1, 2006	New section
Sec. 23	July 1, 2006	New section
Sec. 24	July 1, 2006	New section
Sec. 25	July 1, 2006	5-239a
Sec. 26	July 1, 2006	10-76d(a)(9)
Sec. 27	July 1, 2006	17b-597(a)
Sec. 28	October 1, 2006	17a-22j(b)
Sec. 29	October 1, 2006	17a-22j(c)

Sec. 30	<i>October 1, 2006</i>	17a-22l
Sec. 31	<i>July 1, 2006</i>	New section
Sec. 32	<i>from passage</i>	New section
Sec. 33	<i>October 1, 2006</i>	38a-226c(a)(12)
Sec. 34	<i>October 1, 2006</i>	38a-478l
Sec. 35	<i>October 1, 2006</i>	New section
Sec. 36	<i>July 1, 2006</i>	New section
Sec. 37	<i>July 1, 2006</i>	New section
Sec. 38	<i>July 1, 2006</i>	SA 02-7, Sec. 1
Sec. 39	<i>July 1, 2006</i>	12-818
Sec. 40	<i>from passage</i>	PA 05-280, Sec. 55
Sec. 41	<i>from passage</i>	New section
Sec. 42	<i>from passage</i>	New section
Sec. 43	<i>from passage</i>	New section
Sec. 44	<i>July 1, 2006</i>	New section
Sec. 45	<i>from passage</i>	New section
Sec. 46	<i>July 1, 2006</i>	17b-28(a) and (b)
Sec. 47	<i>from passage</i>	New section
Sec. 48	<i>October 1, 2006</i>	New section
Sec. 49	<i>July 1, 2006</i>	17b-261
Sec. 50	<i>July 1, 2006</i>	New section
Sec. 51	<i>July 1, 2006</i>	New section
Sec. 52	<i>July 1, 2006</i>	New section
Sec. 53	<i>July 1, 2006</i>	New section
Sec. 54	<i>from passage</i>	17a-317
Sec. 55	<i>from passage</i>	Repealer section